# DOCUMENT RESUME

ED 205 298 PS 012 334

TITLE Health Services for the School-Age Child: Suggested Guidelines for School Districts.
INSTITUTION Oregon State Dept. of Education, Salem.
PUB DATE 81
NOTE 100p.

EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS Communication Disorders: Disease Control: Elementary Secondary Education: Guidelines: Health Education: *Health Services: Immunization Programs: *Program Development: *Program Evaluation: Recordkeeping: Screening Tests: Special Health Problems: State Legislation: Teacher Role
IDENTIFIERS Emergency Medical Services: *Oregon

ABSTRACT

Organized around eight topics, this document provides guidelines for Oregon school district health services programs for students in preschool/kindergarten through grade twelve. A list of principles related to health program development, a summary of related health legislation, and a checklist for assessing compliance with Oregon administration rules are included, as well as suggestions for program development. Additionally, the teacher's role in health problem detection and referral is defined, and screening procedures for vision, hearing, height and weight, posture-scoliosis, teeth, and blood pressure are discussed. Subsequent sections cover communicable disease control and related responsibilities, emergency health care, and special health considerations (such as medication, child abuse, alcohol and drug abuse, pregnancy, suicide prevention, chronic health conditions, handicapping conditions, and health counseling). Finally, the topics of health records and health education are briefly discussed. Almost all of the sections of the document offer a checklist of statements for assessing the adequacy of school district health provision. Excerpts from legislation related to health care, guidelines for immunization, a communicative disorders program guide, growth charts, and screening forms are appended. (Author/RH)

***********************************************************************
* Reproductions supplied by EDRS are the best that can be made
* from the original document.
***********************************************************************

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

ED205298

# HEALTH SERVICES FOR THE SCHOOL-AGE CHILD

## 1981

PS 012334

1859

**Verne A. Duncan**
**State Superintendent**
**of Public Instruction**

**Oregon Department of Education**
**700 Pringle Parkway SE**
**Salem, Oregon 97310**

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Oregon Dept. of Education
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

# HEALTH SERVICES FOR
# THE SCHOOL-AGE CHILD

## Suggested Guidelines
## for School Districts

Spring 1981

Oregon Department of Education
Salem, Oregon 97310

Federal law prohibits discrimination on the basis of race, color or national origin (Title VI of the Civil Rights Act of 1964); sex (Title IX of the Educational Amendments of 1972 and Title II of the Vocational Education Amendments of 1976); or handicap (Section 504 of the Rehabilitation Act of 1973) in educational programs and activities which receive federal assistance. Oregon laws prohibiting discrimination include ORS 659.150 and 659.030. The State Board of Education, furthermore, has adopted Oregon Administrative Rules regarding equal opportunity and nondiscrimination: OARs 581-21-045 through -049 and OAR 581-22-205.

It is the policy of the State Board of Education and a priority of the Oregon Department of Education to ensure equal opportunity in all educational programs and activities and in employment. The Department provides assistance as needed throughout the state's educational system concerning issues of equal opportunity, and has designated the following as responsible for coordinating the Department's efforts:

Title II—Vocational Education Equal Opportunity Specialist
Title VI—Equal Education and Legal Specialist
Title IX—Associate Superintendent, Educational Program Audit Division, and Equal Education and Legal Specialist
Section 504—Specialist for Speech, Language and Hearing, Special Education Section

Inquiries may be addressed to the Oregon Department of Education, 700 Pringle Parkway SE, Salem 97310 or to the Regional Office for Civil Rights, Region X, 1321 Second Avenue, Seattle 98101.

Additional copies of this publication may be obtained from:

Oregon Department of Education
700 Pringle Parkway SE
Salem, OR  97310

-or-

Oregon State Health Division
1400 SW Fifth Avenue
Portland, OR  97201

3605519813000

# FOREWORD

The purpose of this publication is to assist Oregon school districts with the development and implementation of health services programs for students in preschool/kindergarten through grade twelve. The document replaces the 1974 publication, Health Services for the School-Age Child in Oregon, and is designed to conform to the 1980 standard for health services, OAR 581-22-705.

The publication was developed over a period of two years by a committee representing school administration, school health nursing, public health, professional medicine and health education. It was reviewed by many other individuals as well, and the combined effort of all these people has demonstrated their dedication to working cooperatively with parents to protect, promote and improve student health. It is just such alliances that will help us achieve our overall goal of excellence in Oregon schools.

The format of this publication has been designed to allow for future revisions. School district procedures may be added to the manual for ready reference.

For further information, contact the Student Services Section at the Department, 378-5492 or toll free 1-800-452-7813.

Verne A. Duncan
State Superintendent of
Public Instruction

# INTRODUCTION

OAR 581-22-705, "Health Services," requires that each school district shall maintain a prevention-oriented health services program for all students. Providing health services, along with maintaining a healthful environment and offering health education are the three major components of a total school health program. They often overlap and complement one another. With a goal of protecting, promoting and improving the health of the school-age child, school personnel join in a team effort with parents and health professionals in the community to: (1) identify students with health problems and refer them to appropriate resources, (2) maintain a safe and healthful environment for students, and (3) encourage students through education to assume responsibility for their own health.

This publication addresses the "health services" portion of the total school program. Responsibility for the health services program is vested in the school superintendent by the school board. Patterns of organization in each district will vary according to the number of children enrolled in the school district, the nature of student health needs, administrative philosophy, policies and practices; legal considerations; community resources and available leadership.

# TABLE OF CONTENTS

Page

Foreword . . . . . . . . . . . . . . . . . . . . . . . . . . . iii

Introduction . . . . . . . . . . . . . . . . . . . . . . . . . 1

Developing a School Health Services Program . . . . . . . . . . 3

Positive School Environment . . . . . . . . . . . . . . . . . . 9

Health Appraisal . . . . . . . . . . . . . . . . . . . . . . . 13

Communicable Disease Control . . . . . . . . . . . . . . . . . 25

Emergency Health Care . . . . . . . . . . . . . . . . . . . . 29

Special Health Considerations . . . . . . . . . . . . . . . . . 31

Health Records and Information . . . . . . . . . . . . . . . . 43

Health Education . . . . . . . . . . . . . . . . . . . . . . . 45

Appendixes . . . . . . . . . . . . . . . . . . . . . . . . . . 49

# DEVELOPING A SCHOOL HEALTH SERVICES PROGRAM

## Background and Purpose

The purpose of a school health services program is to protect, promote and improve the health of the school-age child. The scope of the program is determined by student needs and school and community resources.

The environment in which students work and play influences their health, habits, attitudes, comfort, safety, and working efficiency. Parents have the right to expect that the school will be a safe and healthful place for students. The environment is the responsibility of the school administration; helping to maintain it is the responsibility of students and school personnel, and inspecting for environmental deficiencies may be the responsibility of the local health department.

Maintaining safety practices within and outside the school environment, including to and from school, when under supervision of the school, is the responsibility of school personnel. School staff and students should be aware of their responsibility for their own safety and the safety of others.

The following principles should be considered in the development of the program:

1. Every child has a right to a level of health which will allow for the greatest possible utilization of educational opportunities.
2. A child who is in good health is better able to benefit from the educational program.
3. The health services program should focus on the prevention of health problems.
4. Parents have the primary responsibility for their children's health.
5. The school district has an obligation to protect and promote the health of its students.
6. School personnel should assist parents in carrying out this responsibility and in helping parents to effectively utilize community resources.
7. Teacher involvement is essential to the success of the program.
8. The school health services program should be consistent with the philosophy and goals of the total school program.
9. The school is an integral part of the larger total community, and coordination with community agencies is essential to assure that the health needs and interests of children will be met.

It is fundamentally important to coordinate services of the entire school staff and cooperatively plan with home and community. Even in cases where a small school lacks a health specialist and has limited community resources and facilities, a basic program can be adapted to its needs. Large school systems should be able to provide a comprehensive program utilizing a wide range of professional personnel and resources, to fully implement recommended policies and procedures.

8

## State Standard for Health Services*

What is required by OAR 581-22-705, "Health Services"?
- The standard requires that the district maintain a prevention-oriented health services program for all students, with specific features identified in the rule, (1)(a) through (1)(f).
- The standard requires a space separated from other students for ill or injured students.
- The standard requires that school nurses be licensed to practice as registered nurses in Oregon.

**Health Services**

**581-22-705** (1) The school district shall maintain a prevention-oriented health services program for all students which provides:

(a) Emergency health care, including space separated from other students adequately equipped for providing first aid;
(b) Communicable disease control, as provided in Oregon Revised Statutes;
(c) Health records and health record information;
(d) Adaptation of services for students with special health needs;
(e) Coordination with the health education program; and
(f) Vision and auditory screening.

(2) School nurses employed by a school district shall be licensed to practice as registered nurses.

### Compliance Indicators

- The district maintains a prevention-oriented health services program for all students.
- The program provides for:
  - — emergency health care and separate space for providing first aid,
  - — control of communicable disease,
  - — health records and health record information kept on all students,
  - — services for students with special health needs,
  - — coordination with the health education program, and
  - — vision and auditory screening.
- The school district only employs school nurses who have licenses to practice as registered nurses.

### Commentary

The intent of the health services standard is to assist school districts in designing programs which will assure that minimal health needs of students are met. Teacher involvement in prevention-oriented health services is essential to the success of the program. A child who is in poor health is less able to benefit from the educational program or, in some instances, a child may have a communicable disease which endangers others. Health services include procedures required by law, as well as procedures which prevent health problems, such as good recordkeeping, adaptation of services for special needs, and coordination with the school health education program.

This standard requires that a separate space under proper supervision be provided for ill or injured children. In small schools, this requirement can be met by placing a bed or cot in the principal's office or adjacent room where ill or injured children may lie down. Having these children sit in the main office where others frequently pass should be avoided.

---

*The Standards for Public Schools, as Oregon Administrative Rules, have the force of law. The "compliance indicators" are used by Department of Education staff to determine school district compliance with the rules. The commentary further clarifies the language in each rule as well as the Board's intent when adopting the rule.

Each school district is required to meet the Health Services Standard. The district should have written plans to describe the health services program, including job descriptions. The program should evidence mutual understanding and cooperation among members of the health services team, and its effectiveness in delivering services to students should be evaluated.

The following checklist furnishes data which helps to determine school district compliance with OAR 581-22-705.

Health Services Standard 581-22-705

District & School ____________________

Interviewee ____________________

Interviewer ____________________

Health Services/District & School

1. ___ yes ___ no A space separated from other children is provided for ill or injured children which is adequately equipped for providing first aid.

2. ___ yes ___ no Teachers have been given direction to observe children for early symptoms of common communicable diseases and to notify principal or school nurse when communicable disease is suspected.

3. ___ yes ___ no Procedures have been established to screen children for communicable disease and to exclude them from school if a student is suspected to have been exposed or afflicted with a communicable disease.

4. ___ yes ___ no Health records are maintained for each child in the school in accordance with state and federal student record laws and rules.

5. ___ yes ___ no Students with special health needs have been provided with adaptation of services.

6. ___ yes ___ no Evidence has been provided that coordination exists between health services and the health education program.

7. ___ yes ___ no Evidence has been provided that visual and auditory screening is provided for all children at appropriate levels.

8. ___ yes ___ no School nurses are licensed to practice as registered nurses in Oregon.

Comments: ____________________________________________

____________________________________________

## Suggested Procedures for Program Development

A. Formation of a Planning Committee:

1. Membership

   - Individuals who are interested in and committed to the protection and promotion of student health.

   - Persons representing health professions, local organizations and agencies, students, parents, and school personnel.

2. Purpose

   - To review present services and present to the school board and district administration plans for the district school health services program, based on assessed student needs.

   - To serve as the Health Services Advisory Committee with responsibilities for reviewing goals and needs, evaluating program effectiveness and making recommendations to the administration for program improvement.

B. Committee Responsibilities:

1. Review state and federal legal requirements relating to school health services.

   - Oregon Administrative Rules

     - Health Services, OAR 581-22-705
     - Emergency Plans and Safety Programs, OAR 581-22-706
     - Attendance Requirements, OAR 581-22-316(3)

   - Oregon Revised Statutes

     - Communicable disease control including immunization and treatment, ORS 433.255-.275,
     - Child Abuse,
     - Medical treatment for students over 15 years of age,
     - Administering medications in school,
     - Educational programs for pregnant students under handicapped child statute.

   - Federal Laws

     - Occupational Health and Safety Act (Does not apply to students)
     - Handicapped Child Law PL 94-142

2. Clarify the district's position regarding its school health services program.

3. Identify health needs of students--

   - Health maintenance needs of school-age children
   - Health problems which are prevalent among school-age children
   - Health problems which are unique to the local community

4. Determine program goals to include such areas as--

   - Healthful school environment
   - Health appraisal and follow-up
   - Communicable disease control
   - Emergency health care
   - Special health needs (child abuse, handicaps)
   - Health counseling
   - Health records and information
   - Coordination with health education program

5. Develop a plan to implement the program goals, considering--

   - Services to be provided (i.e., health appraisals might include vision, hearing, scoliosis, height and weight, hypertension screening)

   - Objectives for each service to be provided

   - Policies, procedures, personnel, facilities, and supplies necessary to carry out services

   - Evaluation procedures for each service (indicators for evaluation use are included in each chapter of this publication)

Program Implementation and Evaluation

1. Implement as outlined in 4 and 5 above. (Procedures are suggested throughout this publication. Please note that schools must set aside a space, separated from other students, adequately equipped for providing first aid for ill or injured students.)

2. Evaluate effectiveness of services (i.e., was the program carried out as planned and were the objectives achieved?) Indicators for use in evaluation are included in each chapter of this publication.

# POSITIVE SCHOOL ENVIRONMENT

## The School Climate and the Emotional Growth of Students

The school's influence on healthful student development depends upon the maintenance of a learning environment which protects and promotes mental and physical health. Safe and attractive physical surroundings and an emotional climate free from unnecessary tension and stress are conducive to optimum learning and creative expression. The teacher should maintain a classroom environment in which respect, concern for, and acceptance of others prevail. School personnel are encouraged to develop positive working relationships with parents.

What is the school staff's responsibility for providing a positive school environment?

- The school staff's responsibility is to be open and sensitive to the needs of students and make appropriate referrals.

What is the school staff's responsibility for children who are frequently disruptive in the school?

- The school staff's responsibility is to discuss the problem with the parents, make a decision as to the severity of the problem and take appropriate steps for correction or referral to school or community agencies.

Where can the parents and the school obtain assistance for students with emotional or behavioral disturbances?

- Assistance may be obtained from county health departments, child guidance clinics, the Mental Health Division of the Department of Human Resources, or private practitioners who specialize in treatment of children.

Schools should expose students at every grade level to a variety of positive learning experiences. Opportunities to achieve success, to identify emotions and deal with them appropriately, to make decisions with knowledge of the consequences, and to assume responsibility for various tasks - all contribute to the students' improved self-image and total development. In addition, students should receive guidance in establishing appropriate relationships with adults and peers, as an ongoing process from kindergarten through grade 12.

## Teacher Observation

The teacher must be alert to students showing signs of physical problems and continually watchful for signs of emotional disturbances. Sometimes it is extremely difficult (even for professionals) to distinguish a student's emotional problems from those of a physical nature. Some behavioral patterns which warrant referral by the observant teacher for psychological assistance may include:

- Constant attention-seeking
- Inattentive; daydreaming
- Unhappy; depressed; withdrawn
- Lack of confidence; low self-esteem; self-censure
- Stuttering or other forms of speech difficulty

- Bullying; domineering, overaggressive; cruel
- Antagonistic; negativistic; continually quarreling
- Frequently teased; often the scapegoat
- Poor accomplishment in comparison with ability
- Lack of appreciation of property rights; stealing; vandalism;
- Truancy; frequent absences
- Drug or alcohol abuse
- Fearfulness
- Tantrums
- Unusual or bizarre behaviors
- Self-destructiveness
- Numerous or frequent somatic complaints

NOTE: Children with special needs, including handicaps and disabilities, particularly should be observed to determine whether they require assistance.

## Referral, Evaluation and Treatment

If the teacher identifies student behavior which contributes to learning difficulties or classroom disruption, the teacher should discuss the matter with the principal, counselor, or school nurse. If it is agreed that a problem may exist, the parents should be contacted and the principal, counselor, or nurse may refer the child to the appropriate school or community support service for a more specific evaluation. From this evaluation, a plan for treatment should evolve, if needed. Resources for such evaluation and treatment will vary from one community to another. Under the best of circumstances, the resources might include an interdisciplinary team comprised of an administrator, the student's teacher, the student's school counselor, a school or community health nurse, a social worker, a psychologist, a psychiatrist and the student's parents.

When mental health resources are not readily available, the principal, counselor, or nurse may consult with the district health coordinator or specialist, or with the county health department, to identify sources of help. In some communities, the Mental Health Division of the Department of Human Resources and child guidance clinics can offer assistance. The Mental Health Association of Oregon provides literature on prevention of mental disorders and promotes legislation to improve mental health conditions for the citizens of Oregon.

## Positive School Environment Indicators

Circle the appropriate number (Never-0, Seldom-1, Most of the Time-2, Always-3, Not Applicable-4)

| | | | | | |
|---|---|---|---|---|---|
| The physical environment of classrooms is attractive and safe. | 0 | 1 | 2 | 3 | 4 |
| Teachers maintain a classroom environment free from unnecessary tension. | 0 | 1 | 2 | 3 | 4 |
| Teachers provide students with opportunities for emotional growth (e.g., to improve self-image, learn to deal appropriately with emotions, make decisions, and assume responsibility). | 0 | 1 | 2 | 3 | 4 |

| | |
|---|---|
| Teachers routinely observe students and call to the attention of the principal, counselor, or nurse those who evidence special needs. | 0 1 2 3 4 |
| The school has access to support services to whom students with special needs can be referred for specific evaluation and/or treatment. | 0 1 2 3 4 |
| Students are provided instruction about human sexuality, drug abuse and other topics which have an impact on the individual's mental health. | 0 1 2 3 4 |

# HEALTH APPRAISAL

A health appraisal is the process of determining a student's overall health condition through such means as physical assessment, screening tests, review of student's health history, immunization status, and student observation. The appraisal may be needed for either preventive or corrective purposes. The objectives of the health appraisal are to adequately understand and follow-up on health conditions which may be adversely affecting the student's ability to learn. While parents have the primary responsibility for the health of their children, the school is responsible for the safety and well-being of students while they are in school.

Is a physical examination required by law when children enter school in Oregon?

-No, Oregon law does not require physical examinations for nonhandicapped children for school entry.

Is a physical examination required by law when students participate in interscholastic sports?

-No, however, school district board policy may require such physical examinations as recommended by the Oregon School Activities Association.

What is required by Oregon statutes and rules in terms of health appraisals?

-The school must assure that each student has proper immunization as required by Oregon law. (See appendix.)

-The school must have a program for vision and auditory screening.

Screening helps to identify quickly and easily those students who may need referrals. It should be simple enough to identify possible problems, yet thorough enough to avoid overreferral.

Teachers' observations throughout the school year are essential in detecting poor health habits and possible health problems. The school nurse should be notified of any significant observations regarding conditions which appear to interfere with the student's learning such as:

- Frequent absence because of illness
- Tired appearance; pale or not well
- Poor coordination
- Crippling conditions
- Frequent colds, sore throats, and difficulty in breathing
- Skin or scalp eruptions, or rashes, even though under medical care
- Poor food habits/nutrition
- Vision, hearing, or speech problems
- Heart or kidney conditions, diabetes or epilepsy
- Dental problems
- Any other seemingly ~~abnormal~~ condition (refer to specific appraisals outlined in the sections that follow)
- Lack of proper immunization

The nurse should call the matter to the attention of the parents and, with the teacher, plan a course of action for the student, e.g.:

- Make adjustments in the school routine and environment
- Provide the pupil with instruction regarding the particular health problem
- Await the results of further observation by the teacher
- Refer the student for special testing or evaluation

It is recommended that school districts maintain a current list of agencies and/ or services which may help families to follow up on referrals. In addition:

- Note referral and action taken on the Oregon School Health Record Card. Record observations objectively.
- Avoid judgmental statements.
- Do not attempt to give a medical diagnosis; however, a nurse's assessment is appropriate.
- Provide parents with observations made by school personnel and encourage them to seek assistance for the student.
- Leave selection of a physician to the parent.

## Health Examinations

A. Health examinations are recommended but not required for nonhandicapped children by the Oregon Department of Education for:

- Children entering school
- Children in mid-school years (grade 6 or 7)
- Children entering high school (grade 9 or 10)

B. Health examinations are recommended in grades 7 and 10 by the Oregon School Activities Association for those participating in interscholastic athletic contests. School districts may require a physical examination through adoption of a local board policy. Guidelines for establishing local board policy are contained in Athletics in Oregon, K-12.

C. Health examinations may be given for handicapped children if they have special health needs.

D. Health examinations may be conducted by a physician, physician's assistant, nurse practitioner, registered nurse, or community health nurse especially trained for this purpose.

It is recommended that a parent be present during the examination of an elementary school-age student.

E. Processing of health examination results should include:

- Recording on the Oregon School Health Record Card, the date of examination, name of examiner, and any findings
- Plans for follow-up problems identified

## Immunization Status

Refer to "Communicable Disease Control," the next section in this publication.

## Vision Screening

The Oregon school vision program consists of the administration of the standard Snellen test for distance visual acuity and the observation of children for symptoms of visual defects. This is generally accepted as an effective means to identify children with gross eye defects. Screening by practitioners specializing in a particular field of practice, such as optometrists and ophthalmologists, tends to detract from an integrated health appraisal of the child and may give the impression of definitive diagnosis. It is recommended, therefore, that screening procedures, particularly the Snellen test, be conducted by the school nurse or another person connected with the school who is properly trained. The person may be a trained volunteer or the classroom or homeroom teacher. The Snellen test should be administered in all elementary and secondary schools the first or second month of the school year. The recommended grades are: K through 8, 10 and 12.

The Snellen test is a screening method, NOT a diagnostic test. Examinations beyond the scope of screening are the responsibility and prerogative of the parent. School and health authorities are obligated to inform parents of the need for care, and encourage them to take appropriate action.

A. Teacher observations

Since teachers have the opportunity to observe each child from day to day, they are in a position to notice unusual reactions, conditions, or changes in behavior which may be signs of a visual problem. Observation and inspection by the teacher, and complaints by the students, are as important as an eye test in identifying symptoms. The teacher should note the following and refer for immediate attention.

1. Symptoms based on complaints of the child--

   Pain in the forehead or temples
   Headache
   Blurred vision
   Dizziness or nausea following close eye work
   Definite dislike of reading or other close work

2. Symptoms based on appearance of the child--

   Eyes water while reading
   Frequent styes
   Discharge from the eyes
   Lids often red, encrusted, or swollen
   One eye has a tendency to turn inward or outward when tired
   Frowning, excessive blinking, or wrinkling of the forehead
   Obvious deviation of eye in any direction

3. Behavior--

   Rubs eyes frequently
   Tries to brush away a blur
   Sees blackboard with difficulty
   Holds book close to the eyes

Sits with poor posture when reading
Inattention and symptoms of fatigue while reading
Stumbles or trips over objects
Oversensitive to light
Tension during close work
Shuts or covers one eye when reading
Makes frequent changes in distance from the eyes at which book is held

B. Preparing for Snellen screening--

The Snellen test first should be discussed with the students, and they should understand how they are expected to respond. With younger age groups, it is helpful to demonstrate and practice with the large "E" several days before screening. Thorough preparation will save time and improve accuracy in screening.

Plans for Snellen testing may be incorporated into daily activity schedules. The teachers and nurse should become well acquainted with Snellen procedures before attempting to screen children. Anyone assisting the teacher or nurse also should be thoroughly trained in testing procedures.

Necessary equipment should be at hand and in good condition:

- Snellen "E" chart, for children in preschool, grade 3 and students with language problems
- Alphabet Chart, recommended for grade 4 and above, where student has the ability to read and comprehend
- Window cards of two different sizes
- Eye cover card for EACH child for covering one eye at a time (to be destroyed after one use). A 3 x 5 card is recommended for this purpose; the card may be held obliquely across the nose covering the eye. An occluder may also be used. The occluder or its substitute allows the student to keep both eyes open, but there is no danger of peeking.

The Snellen chart should be placed where there is good lighting, on a table or on a wall. The "30-foot" symbols should be at eye level and a distance of 20 feet (6.1 meters) from the child's eyes. There should be no glare in the child's eyes or on the chart while taking the test. Amount of illumination should be 20-foot candles, as nearly as possible, as determined by a light meter. Light should be evenly diffused on the chart, with no glare.

C. Administering the Snellen Test--

- Place the back legs of the chair on which child is to set on the 20-foot line. If the child stands, the heels should be on the 20-foot line.
- Put the child at ease. Ask him or her to be seated and demonstrate how to use the occluder.
- If the child wears glasses, for distance vision, test with glasses. It is not necessary to test the child without glasses.
- Cover the left eye. An older student may hold the card for the younger children, but a trained individual should give the test. Ordinarily begin at the 50-foot line and proceed downward through the 20-foot line.
- It is satisfactory if the child can read three out of four symbols per line without showing any symptoms (head tilting, squinting, eyes

watering, etc.). The lowest line read satisfactorily is the finding to be recorded; i.e., 20/40, 20/70, etc.
- Leave children who are timid or making a poor adjustment to be screened last in order to achieve their best readings.
- After testing has been completed, store the Snellen "E" chart where it will remain clean.
- Record screening results and observations immediately on the Oregon School Health Record Card. In recording results, the numerator indicates the feet from the Snellen chart (20). The demoninator indicates the lowest line read on the chart; i.e., 20, 40, 50, etc.

D. Referral--

- *Refer to the nurse for rescreening children who:

    have a two-line difference between eyes
    Screen 20/40, 20/50, or above
    Show symptoms of visual disturbance

- Referrals may be made on Form MCH-6, Vision Referral Worksheets. (Sample in appendix.)

- Recommendation for a professional eye examination should be made to the child's parent or guardian on Form MCH-7, Report on School Vision Screening. (Sample in appendix.)

A comprehensive eye examination can be provided by an ophthalmologist or an optometrist. In case of injury or infection, the child should be referred to a physician.

It is important to use a system of follow-up for each referral generated by the screening tests. A school's responsibility should not end when the referral has been made, but should continue through follow-up of any indicated vision problem. The school's record should also indicate, where possible, the nature of the abnormality, as determined by the specialist, and a record of treatment prescribed.

## Common Causes of Eye Disorders in Children

Awareness of some of the common causes of eye disorders will not only help a parent, volunteer or teacher detect problems, but will underline the need for early attention to prevent possible permanent visual damage.

Amblyopia ("Lazy Eye") is the condition that most concerns eye authorities in the young. If it is not discovered and treated before the age of six or seven, it usually leads to permanent reduction of vision in the affected eye. An eye with amblyopia has decreased vision. It may also be crossed inward, turned out or even be straight. In most instances the child has adequate vision in the "good" eye so the parents and teachers are unaware of vision problems. The child rarely complains because the blurred vision causes little difficulty and is perceived to be "normal." The usual treatment is patching the good eye in

---

*In some cases the procedure described in the Eye Care Manual may be preferred.

order to force the use of the weaker one, thus developing improved vision in the "lazy" eye. Sometimes the patch is combined with glasses, surgery or eye exercises.

Strabismus (Squint) is the term used to describe eyes which are not properly aligned, but turn in ("crossed eyes"), out ("wall eyes") or up or down. Strabismus may be due to birth injuries or heredity defects, faulty muscle attachments, excessive farsightedness or certain illnesses. It is rarely outgrown or improved without treatment. Treatment directed toward straightening the eyes can involve glasses, patching, eye drops, surgery and eye exercises, either singly or in combination.

Myopia ("nearsightedness"), Hyperopia ("farsightedness") and Astigmatism ("irregularly shaped cornia") are errors in the focusing system of the eye which usually are considered normal variations of the eye. These frequently found abnormalities are corrected with glasses.

Following is a partial list of suggested initial treatment for common eye injuries and/or illnesses:

Foreign body on lids--May be removed gently with sterile swab. If further problems, refer to ophthalmologist or family physician.

Foreign body on eye ball--Gently irrigate eye; if still present, refer to ophthalmologist or family physician.

Cornea epithelial abrasion--Try to identify abrasion. Inspect for foreign object. Apply occlusive patch for comfort. Refer to ophthalmologist or family physician.

Corneal or scleral perforation or rupture--From sharp and/or high velocity object. Usually easier to recognize distortion of iris than a cut in the cornea. Any brown or black material in the cut is a protruding inner structure of the eye. Do not use an eye patch. Tape a protective shield or paper cup to forehead and cheek over the injured eye avoiding any pressure on the lids. Make arrangements for emergency care with parents and opthalmologist. Calm is more important than confusion and haste. Patient should be kept as quiet as possible.

Hyphema (blood in anterior chamber)--Usually occurs from impact on eye by a fist or thrown rock or ball injury. Identify blood inside eye behind cornea (anterior chamber). Do not force the lids apart. Tape a protective shield or paper cup to forehead and cheek over the injured eye avoiding any pressure on lids. Keep the patient quiet with head elevated 30 degrees or more. Make arrangements for emergency care with parents and opthalmologist. Calm is more important than confusion and haste, and patient should be kept as quiet as possible.

Blow to eye without hyphema--Caused also by impact on eye by high velocity blow. May distort the pupil and diminish vision. Parent should be contacted and care planned with ophthalmologist or physician.

Laceration of eyelid--Gently dress with telfa, if necessary. Refer to ophthalmologist or physician for examination and further treatment.

Black-eye--Black and blue discoloration of the eyelids. Check for eyeball injury by inspecting eye and use of visual acuity test. Apply ice pack. Plan with parents for ophthalmologist or physician's examination.

Chemical injuries--Begin to irrigate immediately, thoroughly and gently with water or eye irrigating solution, whichever is most easily available. Continue irrigation for at least 30 minutes or until ophthalmologist or other physician is reached for further instruction. Inspect eye for any chemical granules and remove. Identify chemical exactly and send name of substance with patient to physician.

Eye infections--Can occur in one or both eyes, are usually noticeable to the teacher, parent or school medical personnel and should be treated as follows:

> Red Eye--This may be an infection called conjunctivitis, which is usually treated with antibiotic drops. Allergies also cause a similar redness. Parents should be contacted for referral to a physician.
>
> Stye--A recognizable swelling on the lid margin, which is noncontagious. It may also appear as a tender lump within the eyelid. Parents should be contacted and a treatment of local wet heat and possible referral to physician are suggested.
>
> Marginal blepharitis--Chronic red scaly eyelids. Treatment by a physician should be planned with parents. In this and any other instance of eye infection the physician should be consulted regarding whether the child may remain in school, swim, etc.

## The Eye and Learning Disabilities

The problem of learning disability has become a matter of increasing public concern. A child's inability to read with understanding as a result of defects in processing visual symbols (often called dyslexia) is a major obstacle to school learning. The significance of the problem has led to the generation of numerous diagnostic and remedial procedures, some more effective than others and many of which imply a relationship between visual function and learning.

The following are presented to assist school districts with cases of dyslexia.

- Treatment of dyslexia and other such causes of school underachievement requires a multidisciplinary approach involving medicine, education and psychology in diagnosis and treatment. Eye care should never be instituted as the sole form of therapy when a patient has a reading problem.

- There is no known eye defect which produces dyslexia and associated learning disabilities. Eye defects do not cause reversals of letters, words or numbers and therefore, eye treatment cannot correct such learning disabilities.

- No known, well-controlled scientific evidence supports claims for improving the academic abilities of learning disabled, dyslexic children with treatment based solely on visual training or neurologic organizational training. Such training often has resulted in unwarranted expense and has delayed proper treatment.

- Except in cases with proven correctable eye defects, glasses will not help in the treatment of dyslexia.

- The teaching of children with learning disabilities is a matter best left to educational professionals. Medical specialists may help bring out the child's potential, but the remedial education remains the responsibility of educators. Medical specialists should work with parents, teachers, and school medical personnel to design a specific series of treatment.

- The causes of learning disabilities often can be detected by the time the child is three years of age. No one remedial approach is universally successful. A change in any variable may increase motivation and reduce frustration for a student. Parents should be made aware that intellectual and psychological factors contribute importantly to a child's scholastic success or failure.

## Hearing Screening

The early identification of hearing impairment is important medically and educationally. The Oregon State Health Division provides an organized program of hearing screening and audiologic follow-up. Although the audiometric screening program is the responsibility of the State Health Division, local school districts may choose to have audiometric testing facilities available.

A. Recommended for annual screening are:

  - all children in grades kindergarten, 1, 3, 5
  - all teacher referrals
  - all children new to the school system

B. Students failing the first screening should be rescreened in six weeks.

C. All children who fail second screening should be referred to appropriate resources--medical or audiological.

D. Assure that follow-up care has been obtained for each student referred, and that information is recorded on the Oregon Health Record Card. (See appendix: Communicative Disorders Program Guide from Mental Health Division.)

## Height and Weight Screening

It is recommended that students attending Oregon schools be weighed and measured once a year, or more frequently if problems develop. The data should be recorded on the Oregon Health Record Card and referred to the school nurse when they are above or below the graduated deviations from normal indicated for the student's age group. (See charts in appendix.) A sudden change in the student's pattern of growth also should be considered reason for referral to the school nurse. Suggested procedure:

A. Weight--See appendix.

  - Check the scales and, in the event they are out of balance, adjust them properly.

- Have pupils remove shoes and sweater, coat, or jacket and stand in the center of the scales.

- Determine weight to the nearest one-half pound/Kgms.

B. Height--See appendix.

- Use a measure fixed in an upright position and a "headpiece" having two faces at right angles. The measure may be an accurate measuring tape fastened either on a special board or directly on a smooth wall.

- Have pupils remove shoes and stand with heels, lower back, shoulders, and rear of head in contact with the wall and board, heels together but not touching one another, arms hanging at sides in a natural manner and the head facing straight forward.

- See that the heels are kept in contact with the floor, that the trunk is maintained in "nonslumped" contact with the measure, and that no obstruction (e.g., comb, clasp, ribbon or braid) prevents contact with the head.

- Record height to the nearest one-fourth inch, or centimeter.

## Posture-Scoliosis Screening

The purposes of conducting posture-scoliosis screening are: to note early postural changes which are deviations from the norm (see charts in appendix), to recommend that these changes be brought to the attention of the parent and family physician or orthopedist, and to emphasize normal development and growth through a well-organized and adaptive program of physical education.

A. Posture-Scoliosis screening is recommended for students in grades 6-9; however, some consideration should be given to younger students in grade 5, depending on growth patterns. School personnel can be trained to conduct posture-scoliosis screening.

B. Students with deviations should be referred to their school nurse, private doctor, school physician, or nurse practitioner for confirmation and referral to a specialist.

C. Resources for long-term treatment might be available through such resources as the Shriners Hospital, Crippled Children's Division, University of Oregon Health Sciences Center and private practitioners.

D. All findings and follow-up should be recorded on the Oregon School Health Record Card.

## Dental Screening

General health, well-being, and personal appearance may be affected adversely by the neglect of dental health. Proper diet, good oral hygiene, and fluorides are three factors that influence good oral health. Proper diet should include the nutrients and vitamins necessary for good total health and exclude frequent intake of sugars. Good oral hygiene includes daily removal of the bacterial accumulation (plaque) by flossing and brushing. Dental health education emphasizes all of the above factors and regular visits to the dentist. Districts may wish to deal with dental screening by sending a notice to the parents to have the child checked by the dentist.

A. Dental observations:

Oral disease is considered to be any abnormal condition affecting the teeth, their supportive tissues, or other tissues of the mouth. Observations should be recorded on the Oregon School Health Record Card. Some common disorders are:

- Inflamed gums (red and swollen; may be a sign of periodontal disease)
- Large cavities or missing portions of teeth (dental caries)
- Toothaches and gum boils (infection)
- Irregular teeth, particularly protruding upper teech (malocclusion)
- Food debris, or transparent film (plaque) on the teeth; bad breath (poor oral hygiene)
- Speech defects associated with oral conditions
- Growths or persistent sores on the lips, mouth, tongue, or jaw (possible tumors or other pathological lesions)
- Harelip and nasal speech (cleft lip and cleft palate)

B. Comprehensive dental program:

School districts, in cooperation with the state and local health departments, dental society, other interested agencies, and parent groups, are encouraged to develop a comprehensive dental program including prevention, education and referral. Some possibilities are:

- Provision of dental exams and care for the indigent pupil
- "Swish-Swash" (fluoride mouthrinsing) program now practiced in many districts
- Resources from dentists, dental hygienists, dental auxiliaries, or affiliated groups for use in a dental health education program

C. Dental emergencies and suggested initial treatment:

- Hot food burns--Rinse with cool water and follow with a mouthwash of one teaspoon of baking soda in a glass of water.

## Blood Pressure Screening

Blood pressure screening in the schools can be an important health appraisal tool. While much information is available on hypertension (elevated blood pressure) in adults, not as much is found concerning the school-age child. The age at which essential hypertension (i.e., hypertension without an underlying cause) as first expressed is unknown. Children and adolescents with hypertension generally do not have other symptoms. Therefore, detection depends on the measurement of the blood pressure. Detection and control of elevated blood pressure and education about hypertension during the preadult years can alter the course of the disease in adult years, thereby reducing the risk of complications of stroke and heart problems.

A. Screening personnel:

Personnel may be school nurses or trained volunteers who have received orientation and clearance of technique by the school nurse. The volunteers may be registered nurses, Red Cross volunteers, Oregon Heart volunteers, parents, or students who have previously completed the Red Cross "Vital Signs Modules 1 and 2" or an equivalent training program.

B. Recommended for annual screening are:

- students in kindergarten or grade 1 if no record is available
- all 4th and 5th grade students
- all 7th or 8th grade students if there is no record of a recent physical exam
- all 9th, 10th or 11th grade students if there is no record of a recent physical exam

C. Screening and referral:

For screening procedures, see American Heart Association guidelines.

D. Follow-Up Procedure:

Contact parents after referral if you have not heard from them or the physician. Measure that student's blood pressure yearly until graduation. It may prove useful to maintain a list of students needing follow-up.

## Health Appraisal Evaluation

Circle the appropriate number (Never-0, Seldom-1, Most of the Time-2, Always-3, Not Applicable-4)

| | | | | | |
|---|---|---|---|---|---|
| The school district has a policy which rcommends physical examinations upon entrance to an Oregon school. | 0 | 1 | 2 | 3 | 4 |
| The school district has policies and procedures for health appraisal. | 0 | 1 | 2 | 3 | 4 |
| Screening tests for vision impairment are conducted as recommended by qualified personnel. | 0 | 1 | 2 | 3 | 4 |
| Students referred for vision care after screening totaled ____, ____ percent of all children screened. | 0 | 1 | 2 | 3 | 4 |
| The percentage of children referred for vision care who are known to have received follow-up care is __________. | 0 | 1 | 2 | 3 | 4 |
| Screening tests for hearing impairment are conducted as recommended by qualified personnel. | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| Students referred for hearing care after screening totaled ___.___ percent of all children screened. | 0 | 1 | 2 | 3 | 4 |
| The percentage of children referred for hearing care who are known to have received it is __________. | 0 | 1 | 2 | 3 | 4 |
| Provision is made for teacher/nurse conferences. | 0 | 1 | 2 | 3 | 4 |
| Health findings on students are reported to teachers and other appropriate personnel. | 0 | 1 | 2 | 3 | 4 |
| Information is recorded on the Oregon Health Record Card. | 0 | 1 | 2 | 3 | 4 |
| Health appraisal records accompany students from grade to grade and from school to school. | 0 | 1 | 2 | 3 | 4 |
| A follow-up procedure is designated for students with special health problems. | 0 | 1 | 2 | 3 | 4 |
| Steps are taken to ensure needed care for all students taking into account all available resources. | 0 | 1 | 2 | 3 | 4 |
| Home visits or health-related parent conferences are conducted. | 0 | 1 | 2 | 3 | 4 |

## COMMUNICABLE DISEASE CONTROL

Communicable diseases are easily transmitted from one individual to another in the school environment. Adequate control includes prevention (through education, health appraisal, environmental control, sanitation, and immunization) and avoiding the spread of contagion by early recognition of illness, prompt diagnosis and adequate isolation.

What is the school's responsibility in communicable disease control?

- The school must exclude any pupil, teacher or school employee who has been afflicted with or exposed to any communicable disease as defined by rules of the State Health Division. (ORS 433.255 and 433.260--See appendix)

Who is responsible in the school for communicable disease control?

- The school administrator is responsible for sending home a pupil who is suspected to have, or has been exposed to, any communicable disease and must report the occurrence to the local health officer.

What is the school's responsibility for assuring immunization of children?

- The school's responsibility is to exclude any child who has not received proper immunization, or whose exemption from immunization due to religious or medical reasons (or after 30 days due to records transfer) has not been filed by the parent with the school.
- The school must report on the number of children who are susceptible to communicable disease, and maintain appropriate records on the immunization status of children.

### Communicable Disease Control in Schools

A person who is diagnosed to have a School Restrictable Disease shall not engage, as long as the disease is in a communicable stage, in any occupation which involves direct contact with students in a private, parochial, or public school. A person who is diagnosed to have a School Restrictable Disease shall not attend a private, parochial, or public school as long as the disease is in a communicable stage. This restriction is removed by the written statement of a Licensed Medical Doctor, public health nurse or school nurse that the disease is no longer communicable. School Restrictable Diseases are those Restrictable Diseases for which the infecting dose is readily conveyed by direct contact or as airborne particles. The following list of School Restrictable Diseases may be added to from time to time when the local health officer in cooperation with the school administrator and staff of the State Health Division find it advisable.

### School Restrictable Diseases

Chickenpox
Diphtheria
Measles
Meningococcal Disease
Mumps
*Pediculosis
Pertussis
Plague
Rubella
Scabies
Staphylococcal Skin Infections
Streptococcal Infections
Tuberculosis

---

*Common name is lice. Written statement from parent is acceptable.

The local health officer may allow students and employees with diseases in a communicable stage to continue to attend and to work in a school when measures have been taken to prevent the transmission of disease. Individual school districts and local health departments may adopt additional or more stringent rules for exclusion from school.

## Division of Responsibilities

The control of communicable disease involves the effort and cooperation of several members of the community whose primary responsibilities are outlined below:

A. The local health officer/health department:

- Responsible for protection of the community against communicable disease
- Represents the State Health Division at the local level
- Informs medical profession, school personnel, and community regarding rules, regulations, and policies on the control of communicable disease
- Collaborates with school administrator in developing school health policy
- Advises school officials concerning exclusion of pupils and teachers
- Provides for immunization clinics as necessary

B. The school administrator:

- Develops exclusion and readmission policies and procedures for communicable disease control in cooperation with local health officer (ORS 443.255 and ORS 433.260)
- Enforces immunization requirements of Oregon school entry law (ORS 433.267 and ORS 433.275)
- Notifies parents of child at first sign and symptom of illness; establishes policy on transportation
- Notifies local health department if communicable disease is suspected

C. The parent(s):

- Assures immunization protection for preventable communicable diseases required by law for school enrollment
- Maintains an accurate record by month and year of each child's immunization
- Provides school with immunization record, as required by law
- Keeps child at home if illness is suspected; seeks medical advice as necessary
- Notifies school if communicable disease is suspected or diagnosed by physician

D. The teacher:

- Observes children for signs of illness
- Learns to recognize early symptoms of common communicable diseases of children

- Consults with school nurse if available when child appears ill or has other symptoms of communicable disease
- Notifies principal and follows approved school procedure
- Assists in screening students for communicable disease

E. The school nurse:

- Assists teachers to be knowledgeable about communicable diseases and immunization protection
- Provides nursing assessment of ill children
- Knows community resources and makes appropriate referrals
- Notifies local health department if reportable communicable diseases are suspected even though diagnosis is not confirmed by a physician

Immunization: Immunization against certain communicable diseases is a condition of school attendance for every child through grade 12. To comply with Oregon law (ORS 433.267 and 433.275), parents at the time of school enrollment must provide an immunization record to the school. Required immunizations are: measles; rubella; polio; pertussis (whooping cough); diphtheria; and tetanus.

Requirements of the new law are to provide one of the following:*

- A statement signed by the parent certifying that the child has received immunizations against communicable diseases prescribed by rules of the Health Division.
- A statement signed by a parent, a practitioner with authority to administer immunizations, or a representative of the local health department describing the manner in which the child has begun the immunization process for children excluded for noncompliance.
- A statement, signed by a physician or representative of the health department, exempting the child for medical reasons.
- A statement signed by the parent opposing immunization for religious reasons.

An immunization schedule is presented in the appendix. Additional schedules are available from the State Health Division.

Communicable Disease Control Evaluation

Circle the appropriate number (Never-0, Seldom-1, Most of the Time-2, Always-3, Not Applicable-4)

| | | | | | |
|---|---|---|---|---|---|
| There are well-defined school procedures on control of communicable disease, developed in cooperation with the local health department and local school district. | 0 | 1 | 2 | 3 | 4 |
| School personnel are informed regarding responsibility for the control of communicable disease. How informed? | 0 | 1 | 2 | 3 | 4 |

---

*The effective date of implementation of requirements will be some time in 1982. More detailed information will follow after rules have been developed.

| | |
|---|---|
| Parents are informed about immunization requirements and communicable disease policy. How informed? | 0 1 2 3 4 |
| A person is designated to report cases of communicable disease. | 0 1 2 3 4 |
| All students comply with the Oregon immunization laws ORS 433.267 and ORS 433.275. | 0 1 2 3 4 |

## EMERGENCY HEALTH CARE

In every school there are individuals with the potential for emergency medical problems, either known or unknown to them. In cases of illness, accident or other emergency, efficient and effective school procedures should be available.

What steps should the school take to assure proper emergency health care for students?

- Prepare a plan for emergency services and train staff on procedures.
- Identify trained individuals in the school who can assist in an emergency.
- Have a place separated from other students adequately equipped for providing first aid (see appendix).
- Identify appropriate emergency services and post telephone numbers for contact.
- Have parents provide current medical information on their children and where parents can be reached in a medical emergency.

### Planning

The school needs to have a plan for emergency services that is known to all personnel, with copies posted in the school office and other appropriate locations. Trained first-aid personnel are necessary for emergency health care. Each school should designate an individual to coordinate a first-aid team. The number of adequately trained individuals needed depends upon the size of the school, but must be in compliance with all local, state and federal laws. School personnel should limit themselves to approved first-aid and CPR procedures. They should be aware of the "Good Samaritan Law"--ORS 30.800. (Refer to appendix.)

The emergency plan is the responsibility of the teachers and administrators and should be developed at the school. The school nurse may be the appropriate person to begin development of a plan and implementation of care. Special health considerations in the administration of medication are discussed in the next section of this publication. (See appendix for sample procedure.)

### Equipment and Information

Each building should have first-aid supplies and equipment in accordance with accepted first-aid guidelines. Local district policies, as well as state and federal occupational health regulations, should be followed. A health room or area should be provided to carry on essential school health services and emergency first-aid care. However, on-the-spot first-aid care may be necessary in certain instances. It is recommended that a first-aid kit, manual, blanket and splints be packaged and centrally located to assure easy availability.

Personnel in each school should know about the availability of school supplies and equipment, and of emergency services in the community and vehicles which may be utilized by school personnel when needed in an emergency.

Parents should be asked to provide pertinent medical information about their children, which may affect first-aid treatment or emergency care to be given. Students with major health problems should be identified with all pertinent information readily available. Accessibility of phone numbers for emergency medical care to be utilized, if necessary, is recommended. Teachers are to be notified and provided with sufficient information to act promptly and discreetly. This information should be considered confidential.

## Reporting

Written policies and procedures should be developed locally, outlining a system for reporting school accidents. Major emergencies would include excessive bleeding, breathing difficulty, unconsciousness, shock, poison, suspected impact injuries to the head, neck or back. Other injuries and illnesses include, but are not limited to cuts, burns, splinters, nausea, uncomplicated seizures, etc., which do not ordinarily require emergency medical care.

## Emergency Health Care Evaluation

Circle the appropriate number (Never-0, Seldom-1, Most of the Time-2, Always-3, Not Applicable-4)

| | | | | | |
|---|---|---|---|---|---|
| The building has a plan for emergency health care. | 0 | 1 | 2 | 3 | 4 |
| The building has first-aid trained individuals. | 0 | 1 | 2 | 3 | 4 |
| There are policies and procedures for sending ill or injured students home. | 0 | 1 | 2 | 3 | 4 |
| There is a procedure related to administration of medication. | 0 | 1 | 2 | 3 | 4 |
| There are policies and a procedure for reporting accidents. | 0 | 1 | 2 | 3 | 4 |
| There are first-aid supplies and equipment available in accordance with first-aid guidelines. | 0 | 1 | 2 | 3 | 4 |

# SPECIAL HEALTH CONSIDERATIONS

A student may have special health needs which must be addressed on an individual basis, and consideration of the student's welfare is of vital importance. However, school personnel should be reminded that they cannot usurp parental authority and responsibility.

Special student health considerations include:

- Required medication
- Child abuse
- Alcohol and drug problems
- Pregnancy
- Suicidal tendencies
- Handicapping conditions
- Chronic health problems

The school is frequently the setting where all the disciplines become involved with students and their families and it is imperative that these efforts be coordinated. This can best be accomplished through regular communication with parents, and involving them in recommendations and decision-making.

## Medication

School personnel are frequently asked by parents to assist students in taking prescribed medication during school hours. School districts should have policies and procedures for administering medication.

Ideally, all medication should be given at home; however, PL 94-142 has increased the number of students in the school who have need of medication during the school day. Also, there are students with acute illnesses, long-term health conditions such as epilepsy, cystic fibrosis, hyperactivity, and life threatening health problems such as bee sting allergies that require medication be given in the school setting.

May school personnel administer medication to students?

-Yes, if done under the following conditions:

- written permission of the parents,
- following instructions of a physician,
- following board policy.

May school personnel administer nonprescription medication to students such as cough drops, aspirin, etc.?

-Only under conditions as identified above. The law does not treat nonprescription medication differently from prescription medication.

Any student who is required to take prescribed medication at school should comply with the policies and procedures of the school board. The procedures should include:

- Written orders from a physician indicating the name of the student, name of the drug, dosage, time interval, method of administration that the medication is to be taken

- Written note from the parent or guardian requesting that the school district comply with the physician's order
- Provision that medication brought to school by the parent is to be kept in a container appropriately labeled by the pharmacy or physician
- Designation of one member of the staff to administer medication, preferably health personnel
- A locked container provided for the storage of medication
- Opportunities for communication among the parent, school personnel, and physician regarding the necessity for helping the student to take the medication during school hours
- Notification of the parent or guardian by a designated member of the school staff, as quickly as possible after an emergency occurs. The parent's current telephone number should be available in the student's record specifically for this purpose

The complete text of the statute governing administration of medication in schools is given below:

> "336.650 Liability of school personnel administering medication. A school administrator, teacher or other school employe designated by the school administrator, who in good faith administers medication to a pupil pursuant to written permission of the pupil's parents or guardian and in compliance with the instructions of a physician, is not liable in a criminal action or for civil damages as a result of the administration except for an act of omission amounting to negligence or willful and wanton misconduct."

## Child Abuse

A. Reporting mandated:

All school employees must report or cause a report to be made when there is reasonable cause to believe that a child has been abused. (ORS 418.750) Failure to report may result in a fine of up to $250. (ORS 418.990) Records kept of observed indicators of abuse are considered part of student records.

May school personnel be present when appropriate authorities are interviewing a child following a complaint?

- No law requires that school authorities be present and investigating personnel may require that school officials be excluded. However, school officials may be present if no objection is raised by investigating personnel.

May school district boards set policy which requires school personnel to report suspected child abuse to an administrator rather than to appropriate agencies?

- No, however school board policy may require that the school administration be notified that such a report is made.

"Child" means an unmarried person who is under 18 years of age. "Abuse" means: (a) physical injury caused by other than accidental means; (b) neglect which leads to physical harm (spiritual treatment, solely through prayer via recognized church, allowed); (c) sexual molestation. (ORS 418.740)

The report is made to the Children's Services Division or law enforcement personnel. (ORS 418.755) Required content of report: (a) names and (b) addresses of the child and parents or those having care of the child, (c) child's age, (d) nature and extent of abuse, (e) explanation given for the abuse, and (f) other pertinent information.

Confidentiality of student records does not contradict the required disclosure of information relative to child abuse. (ORS 336.195, PL 93-380 as amended by PL 93-568) Those who make reports are protected from civil and criminal liability when the report is made in good faith based on reasonable grounds (ORS 418.762); however, they may be required to testify in court regarding their observations.

B. Indicators of possible abuse:

Only the court can determine if child abuse has occurred. However, the nonmedical person can assume that when one or more of the following indicators are present, a report should be made:

- Child states that another person caused the injury and that it was not an accident
- Injury which seems to be at variance with the explanation given
- Unusual or repeated bruises
- Repeated cuts, punctures or broken bones
- Undue fear of parents or others
- Untreated injuries or conditions
- Undernourished--frequent reports of no breakfast or dinner
- Apprehension with adults, fear of normal physical contact
- Sudden unexplained changes in behavior
- Frequent prolonged absenses
- Habitual inappropriate dress for weather conditions
- Unusual confinement of child by parent
- Unusual lack of understanding by parent of child's condition

C. Steps taken in suspected cases of child abuse:

- Observe indicators--visible, documentable indicators are preferred
- Make or cause report to be made--follow district policy
- Even if not reporting directly, to the appropriate agency, those who initiate reports are responsible for follow-up to see that the report is received by that agency
- Report again if indicators continue to be observed; evidence may have been insufficient the first time
- Cooperate with the investigator

D. Local policy:

According to the Attorney General's office, school staff persons are not required to notify parents or to be present when Children's Services Division staff or law enforcement officials are interviewing a student on school premises. Law enforcement officials or Children's Services Division may require that school officials be excluded from sitting in on such interviews. School districts may not set policy which requires that school personnel be present during an interview, nor may they set policy which requires school personnel to report suspected child abuse to an administrator rather than to a local law enforcement agency or Children's Services Division office.

## Alcohol and Drug Abuse

The use and abuse of alcohol and drugs by students during the 1960s and 1970s began to pose major problems for school officials. Severe penalties and educational programs to correct the problem were only marginally effective. Alcohol continues to be one of the most prevelent drug problems, while marijuana has become the most common street drug. Some youngsters take several drugs in combination with alcohol.

The social and emotional problems of youth which are frequently encountered in conjunction with the abuse of alcohol or drugs have placed increased pressure on the school to deal with these problems. Youth alcoholism differs from adult alcoholism in that adolescents have not established a norm for each individual's behavior; their development processes can therefore be easily disrupted. Such disruptions may have long-lasting and devastating effects unless early treatment of the condition can begin.

Alcohol and drug abuse poses particular problems for young people who are developing ways to cope with stress and anxiety. Alcohol or drug abuse during this critical time inhibits the development of more constructive approaches. It also inhibits maturation, impairs the formation of satisfying relations with others and effective functioning in education and work.

The school cannot ignore the problems of alcohol and drug abuse. Constructive steps should be taken in cooperation with parents and community resources to deal with the problem. A broad based approach designed to prevent alcohol and drug abuse is recommended.

What steps should the school take to prevent alcohol and drug abuse among students?

- Provide educational programs which develop abilities to cope with stress.
- Provide inservice education of school personnel on how to deal with alcohol and drug abuse by students.
- Encourage school staff to be sensitive and alert to possible alcohol and drug abuse by students.
- Identify referral resources and make appropriate referrals for the student and the student's family.
- The use or abuse of alcohol or drugs on school premises should not be condoned or overlooked. Most districts already have severe penalties for use or abuse. It should be pointed out, however, that punitive action is generally not an effective remedy for these problems.

## Pregnancy

Every effort by school personnel should be made to help pregnant students continue their education toward becoming responsible adults. School and community resources should be fully utilized.

What is the school's responsibility for a pregnant student?

- It is the school's responsibility to inform the student and parents of their rights to continue in the regular education program (if medically able), or to receive special education services or other modified program in the school district or education service district.
- The school must facilitate provision of related services, including counseling, to pregnant students and inform them of the availability of resources provided by other health and social service agencies. (ORS 343.187)
- The school staff should respect the confidentiality of the student until the student is informed of the alternatives and decides what program to pursue.
- If the pregnant student qualifies for services as a handicapped child the school must provide an IEP with a modified curriculum as needed by the student.

It should be noted that minors fifteen years of age and older may contract for their own medical care without parental consent and physicians may provide birth control information to any person, regardless of age.

Oregon law is quite specific regarding the school's responsibility for pregnant students. The students shall not be excluded from public school solely on the basis of pregnancy. Pregnancy is considered a handicapping condition and students have the right to receive special education services. Prior to providing special education services, however, parents must be notified. In most situations, the school will encourage students to tell their parents as soon as possible. Furthermore, under OAR 581-15-051(8) a child is not technically eligible for special education services until the condition is verified by a licensed physician.

Once a pregnancy is verified, and the student and parent have been informed of available services, an IEP (Individual Education Plan) may be established through regular procedures for the handicapped. Since pregnancy is a normal physiological condition, a program may emphasize exercise recommended by the student's physician. Other curriculum might include: health education, nutrition, personal finance, job skills, homemaking and parenting skills. In addition, instruction and counseling on the hazards to an unborn child of using drugs and alcohol may be included.

## Suicide Prevention

Suicide, and suicide attempts, are acts of desperation or extreme anger. Suicide is the third most frequent cause of death among adolescents in the United States; however, the methods are changing, with drugs being more commonly used today. More suicide attempts are made by females, but attempts by males more frequently end in death. The true magnitude of suicide is not known since many are classified as, or thought to be, accidents. The school is involved in the problem of suicide, since it may be the site where the attempt is made or the student may relate the story of the suicide attempt to a member of the school staff.

How should school personnel treat a suicide attempt?

-A suicide attempt should be treated as a medical emergency. No suicidal communication or attempt should be regarded lightly, but should be referred to the appropriate resource.

What steps should the school take to prevent suicides?

-Educational programs should be provided to help students and staff develop methods for coping with stress.

-Inservice education of school personnel should be provided regarding suicide and the student.

-School staff should be sensitive to emotionally confused students.

-Referral resources should be identified and appropriate referrals made for the student and the student's family.

Some possible indications of suicidal tendencies:

- Communicating suicidal thoughts to another person
- Depression
- Sudden behavior or personality changes
- Irritability
- Recent significant crisis or loss
- Withdrawal
- Decreased attention to personal appearance, grooming
- Decrease in school performance/erratic attendance
- Communicating serious problems about peer/family relationships
- Sleep or appetite disturbance

The school district should have policies relating to its community resources in order to provide adequate assistance to the potentially suicidal student. Resources may include the school nurse, counselors in the school or community, family doctor, psychologists or psychiatrists, local mental health agencies, and hospitals.

## Chronic Health Conditions

With increasing frequency, students with chronic health conditions may be enrolled in public schools. Some of these conditions include cardiac diseases, respiratory diseases, diabetes, epilepsy and obesity. The students often can participate fully in the school setting if given appropriate support services.

What is the school's responsibility in dealing with chronic health problems of students?

-The school's responsibility is to identify students with chronic health problems and special health needs, and to assess the current status and overall condition of identified students.

-The school should determine what information is needed and outline school staff responsibilities.

The school nurse is the person most likely to lead the educational team through the process of understanding how a physical disability affects the student's classroom performance and how to provide assistance to the student.

A suggested approach to students with chronic health problems would be:

- Identify any student suspected of having a chronic health problem by reviewing the Oregon School Health Record Cards, copies of physical examination by family physician, enrollment form and other sources.
- Interview the identified student and/or parent to determine the following information:
    - The specific chronic health condition
    - Onset and duration of problem
    - How conditions manifest themselves in this individual
    - How this disability handicaps the student; whether the student can adapt to compensate for disability
    - Current treatment and/or medications, and the student's care in observing these instructions
    - Health care provider
    - Whether student is known to other agencies and if so, the patient's number
    - Parental consent for release of confidential medical information.
- Communicate with the child's health care provider to obtain diagnosis, treatment plans, recommendation for school's approach to the disability, and suggestions for additional services which may be needed.
- Determine all types of school-related problems for the student.
- Plan appropriate nursing interventions, such as alterations in class placement or schedule, schedules for administering medication, conferences with school staff and environmental changes. A determination should be made as to whether this student's learning is adversely affected and whether the student is eligible to receive special education services through PL 94-142. Referrals should be made to appropriate school personnel and/or community agencies.
- Assure that nursing interventions are carried out as planned. All actions should be recorded and evaluated.
- Periodically reassess the student and his or her needs.

## Handicapped Children

The Federal Education for All Handicapped Children Act (Public Law 94-142) was enacted in November 1975 to assure that all handicapped children ages 3 to 21 years are provided a free appropriate education. Special educational services and other related services must be provided by local school districts so that special needs of students may be met. School health services personnel must assume vital roles as members of the interdisciplinary team which develops the individualized educational plan that is required for each student being considered for special educational placement. Health examinations may be given for handicapped children with special health needs.

The first step in implementing this legislation is the development of district policies and procedures. These include identification of handicapped students; verification of handicapping conditions; planning of strategy for meeting needs presented by each student, encouraging positive participation by families in the development and implementation of the individual plan; the classroom implementation of the child's program; and the review and evaluation of such programs. It is imperative that each team member, including school health personnel, be allowed to provide input into planning.

Role of School Health Services Personnel:

Identification of students with handicapping conditions by health screening, health records review and observation is a role which health personnel have always assumed in the school setting. This role became more apparent and vital since PL 94-142 was enacted and implemented.

School health personnel provide a unique point of view when participating as members of admission, review and dismissal committees. By reviewing records and observation, they may determine whether or not additional information about the physical health of the child is needed or would be useful. By using problem-solving techniques, they may assist the group in determining appropriate placement and/or further actions. By utilizing knowledge of community resources available for consultation, evaluation and treatment, invaluable assistance can be obtained for preparing an appropriate plan for each child.

Community health care providers are essential to the identification and planning process of Public Law 94-142. They are needed for providing an accurate assessment of a child's physical abilities and disabilities; assisting in the verification of certain handicapping conditions; providing ongoing treatment; and making recommendations for successful classroom adjustment. School health personnel must serve as a liaison between educational and health agencies. Since much information is received in the form of written reports, school health personnel assure that assessments and recommendations are clearly understood by all team members and are incorporated into plans for the child.

Direct care may be needed in some instances so that the child can benefit from the educational program. Direct care may include assisting the child to take required medications, helping the child learn self-care and personal hygiene and providing occupational and/or physical therapy services.

Families, as well as the students themselves, are often frustrated by the demands placed on them by the school setting. Health professionals may provide counseling to help families and students meet the challenges facing them and eventually to cope with their handicaps and concentrate on the individual's assets.

Teachers and other educational personnel need to understand how physical/neurological conditions may affect or interfere with a child's learning. Inservice programs may be developed to explain the causes and effects of certain conditions. Health programs may also be directed to helping other students understand and accept the physical disabilities of some of their peers.

## HEALTH COUNSELING

Health counseling should be a major part of any health services program. The goal of health counseling is to teach others about preventive health and safety. This is done preferably by the school nurse, with others included to varying degrees. The nurse is a liaison for the school, parents, health professionals and community resources. Each school should have a plan for referral and follow-up.

What is the school's role in providing health counseling for students?

-The school has no specific responsibility to provide health counseling. However, health counseling is a vital part of a prevention-oriented health services program.

A. Counseling with students:

- Provide information regarding health status, as revealed by health appraisal
- Encourage pupils and parents to seek needed treatment
- Encourage pupils to accept and demonstrate responsibility for their own health, in keeping with their maturity
- Contribute to the health education of pupils
- Assist in obtaining educational programs adapted to individual needs and abilities
- Help students accept and adapt to physical limitations

B. Counseling with parents:

- Interpret the significance of health conditions and encourage parents to obtain needed care for their children
- Guide families to appropriate community resources
- Contribute to health education of parents
- Discuss real or potential community health problems

C. Counseling with school staff:

- Give information regarding communicable diseases and exclusion/re-admission policies
- Provide health counseling and inservice programs for school personnel
- Serve as a resource for school personnel

D. Counseling with the community:

- Coordinate the school health services program with community agencies and resources
- Help the community recognize health needs

## Special Health Considerations Evaluation

Circle the appropriate number (Never-0, Seldom-1, Most of the Time-2, Always-3, Not Applicable-4)

### Medication

| | | | | | |
|---|---|---|---|---|---|
| The district has written procedures for administering medication to students in the school. | 0 | 1 | 2 | 3 | 4 |
| Teachers and other staff have received instruction regarding the written procedures. | 0 | 1 | 2 | 3 | 4 |

## Child Abuse

| | |
|---|---|
| School employees are aware of their responsibility to report suspected cases of child abuse. | 0 1 2 3 4 |
| Written procedures for reporting child abuse have been provided to school employees. | 0 1 2 3 4 |
| School employees have received training to recognize indicators of possible child abuse. | 0 1 2 3 4 |

## Alcohol and Drug Abuse

| | |
|---|---|
| The district has a policy for dealing with alcohol and drug problems. | 0 1 2 3 4 |
| The district has a procedure for dealing with medical emergencies. | 0 1 2 3 4 |
| The district has a prevention-oriented educational program for all students concerning the abuse of drugs and alcohol. | 0 1 2 3 4 |

## Pregnancy

| | |
|---|---|
| The district has a policy concerning pregnant students consistent with state legal requirements. | 0 1 2 3 4 |
| The district has a procedure to inform the pregnant student and the parents of the student's rights to special educational services; and the availability of such services within and outside the district. | 0 1 2 3 4 |
| The district has an education program related to human sexuality and pregnancy. | 0 1 2 3 4 |
| The district has a procedure to provide the student and parents with information concerning available community resources related to pregnancy. | 0 1 2 3 4 |

## Suicide Prevention

| | |
|---|---|
| The district has educational programs which help develop methods for coping with stress, for: | |
| • students | 0 1 2 3 4 |
| • school personnel | 0 1 2 3 4 |
| The district has a procedure for dealing with a suicide attempt as a medical emergency. | 0 1 2 3 4 |
| The district provides information regarding available counseling and medical resources to potentially suicidal students and their parents. | 0 1 2 3 4 |

### Chronic Health Conditions

| | |
|---|---|
| District personnel review health records periodically to identify students having chronic health conditions. | 0 1 2 3 4 |
| District personnel develop and carry out plans to resolve school-related problems of the child having a chronic health condition. | 0 1 2 3 4 |
| Programs for students with chronic health conditions are reevaluated annually. | 0 1 2 3 4 |

### Handicapped Children

| | |
|---|---|
| The district has policies and procedures for identifying and serving handicapped children. | 0 1 2 3 4 |
| Children who may possibly need services are identified and referred. | 0 1 2 3 4 |
| Liaison with school and community agencies and/or health care providers assure good service to child and family. | 0 1 2 3 4 |
| Direct health services are provided as needed to handicapped children. | 0 1 2 3 4 |
| Health counseling is provided to handicapped students and their families to help understand and cope with disability. | 0 1 2 3 4 |
| Consultation and inservice training are provided to teachers and other educational staff regarding physical needs of handicapped students. | 0 1 2 3 4 |

## HEALTH COUNSELING

| | |
|---|---|
| The school has a plan for follow-up relating to health conditions. | 0 1 2 3 4 |
| The school nurse is available for health counseling. | 0 1 2 3 4 |
| Health information will be shared among school nurses, school counselors, psychologists, and teachers. | 0 1 2 3 4 |

# HEALTH RECORDS AND INFORMATION

An Oregon School Health Record Card should be started when each child enters school and should follow the student as he or she moves from grade to grade and from school to school. All student health records are confidential and should be released only in accordance with applicable state and federal laws. School personnel should be very careful about sharing any information that might prove speculative or damaging to any student.

Should the Oregon School Health Record Card be forwarded without written permission of the student's parents?

-Yes, school law requires that all progress records be forwarded upon notification that the student has enrolled in another educational institution. No parental permission is required.

Are health records available to parents or legal guardians of a student?

-Yes, all student records, including health records, must be made available to parents or legal guardians within a specified time not to exceed 45 days.

For how long should the records be kept?

-Health records should be kept until the individual reaches age 25. Accident report forms: minor accident, 7 years; serious accident, permanently.

## Oregon School Health Record - Form 581-3411

The Oregon School Health Record is a part of the student's progress record. (ORS 336.185) Records of behavior or conversation should be kept in the behavioral file. Personal working notes of a nurse or other certificated staff may be kept confidential as long as they are in the possession of the maker. Student progress records, including health records, shall be available to parents or legal guardians, and with parent permission, to other agencies or institutions requesting such records. They may be made available to all teaching staff depending on local board policy. The health record card must be transferred with other progress records when the student moves from the school.

An effective use of the card is to annually review each student's record with identification of health problems and formulation of appropriate remedial actions.

## Recording on the Oregon School Health Record Card

The Oregon School Health Record Card can help to determine the needs, interests and capacities of the student. Specific health information about the student should be current, concise and pertinent. Information may be recorded by the nurse if one is available or by a paraprofessional, aide or volunteer under the supervision of a nurse or a certificated staff member.

The student's immunization record should be kept up to date by the school and appropriate entries made in the record.

## Suggested Storage

The student health records must be stored in a manner and location where those using the record can have ready access. Generally these records are kept in close proximity to the person or persons who maintain and use the record. Maintenance and supervision of the record as well as accessibility are important criteria for determining the location.

The health records should not be stored in an area of heavy traffic or where unauthorized persons could have access. Storage with other student records is recommended unless this location would create an inconvenience for the school nurse or other person using the health record.

## Health Records and Information Evaluation

Circle the appropriate number (Never-0, Seldom-1, Most of the Time-2, Always-3, Not Applicable-4)

| | | | | | |
|---|---|---|---|---|---|
| Each pupil has a health record card on file. | 0 | 1 | 2 | 3 | 4 |
| A system exists for review and maintenance of the student's health record information. | 0 | 1 | 2 | 3 | 4 |
| The health record is transferred when a child changes schools. | 0 | 1 | 2 | 3 | 4 |

# HEALTH EDUCATION

Although this publication is dedicated to the health services component of the total school health program, the relationship of health services to health education cannot be overlooked. The two are so closely interrelated that they draw from each other to achieve their goals. The teaching staff plays a specific supportive role in the school health services program, and school health services personnel, in turn, are outstanding resources for teachers in the health education classroom.

What steps should the school take to assure coordination between health services and health education in the school?

- The school health services committee should include health education personnel.
- The school health services plan must specify how the program is coordinated with health education.
- Roles of health education and health services personnel should be identified in a manner which avoids duplication and builds upon complementary activities.

## Education about Health Services

Plans for school health services should be communicated to those who will be affected: letters explaining the programs may be sent by the school or health department to parents, educational sessions may be held for teachers and students, and health information can be disseminated by the media.

Certain school health services, such as vision and hearing screening, are routine and do not require special notices to parents, or parental permission. However, other special health services, such as a specific immunization and the fluoride mouthrinse program, require that educational materials be sent to parents explaining the necessity for the program, procedures to be followed and expected outcomes. Parents are requested to give their permission for their child's participation in the program. Even though students age 15 and above can by law sign for their own health care, it is important that parents be notified about the service to be rendered. Knowledgeable parents generally support the health services to be provided.

Students should be informed before a service is to be provided. With permission from the school administrator and the teacher, health services personnel may go directly to the classroom to present the information to students, or they may find it desirable to hold informative sessions for the teaching staff who, in turn, will relate the message to their students. Educating students about the service eliminates misconceptions, apprehensions and fears.

Students should understand the reason for the service, the procedures to be followed, and the benefits which will result from it. Students in intermediate grades and above will develop a greater understanding of and appreciation for the service to be provided if they can learn about the body parts to be screened or about the disease for which immunizations are to be given. For instance, when vision, hearing, dental or scoliosis screening is to be done, a study of the structure and function of the eye, ear, teeth, or spinal column will make the screening more meaningful. If immunizations for a specific disease are to be given, students at these grade levels will benefit from learning about the disease and its complications and how its vaccine was discovered. Cooperation of the health teacher in this educational effort reinforces the importance of and the need for the health service to be provided.

The media can be an important ally to schools and health departments when a health service is to be provided to all schools within the community. Cooperation of local newspapers and radio and television stations in disseminating information to the public creates an awareness of the program and its benefits, and builds public support of the service.

## The Role of Health Services Personnel in the Health Education Program

In addition to educating students, parents and the public about health services to be provided, health services personnel also can contribute a great deal to the health education program which is conducted, generally, by elementary school homeroom teachers and by middle, junior high and high school health teachers. Since the classroom health education program includes a wealth of subject matter, the teacher must be creative in planning a variety of learning experiences and be skilled in using teaching strategies to help students develop desirable health attitudes and habits. Teachers who are insecure with health subject matter or who want current information must be given opportunities to gain knowledge and acquire skills that will enable them to exhibit confidence in the classroom. In this respect physicians, dentists, nurses, psychologists and others involved with the health services program can assist with teacher preparation by offering to conduct workshops or instruct inservice classes.

Health services personnel occasionally may be invited by the teacher to serve as resource persons in health education classes to discuss specific health topics. Input from health services personnel can enhance the program immeasurably. They should, however, not assume responsibility for the complete health education program even though a teacher might request that they do so. Resource persons should be utilized wisely and sparingly.

The teacher is the best judge of subject matter suitable for students at a particular grade level. He/she should request the services of a resource person only after careful consideration of the contribution that person would make to the health curriculum and after students have been prepared for the person's visit. For example, the nurse can be an especially valuable resource during units on personal hygiene, menstruation and communicable disease, while the dental hygienist can assist with the unit on oral hygiene. Resource persons may bring with them publications and audiovisual aids, and they can advise teachers about other sources of information.

The school nurse is usually the most accessible member of the school health services team. Whereas the nurse is primarily responsible for imparting health information and counseling students about health matters, and the teacher for the classroom health education program, the two must work together if the goals of the total school health program are to be accomplished.

In summary, health services personnel and the health education teaching staff should cooperate to provide educational experiences for students which will lead to the development of positive, lifelong health practices.

## Health Education School Evaluation

Circle the appropriate number (Never-0, Seldom-1, Most of the Time-2, Always-3, Not Applicable-4)

| | | | | | |
|---|---|---|---|---|---|
| Parents are aware of health services to be offered/provided students, and, when appropriate, their permission is requested. | 0 | 1 | 2 | 3 | 4 |
| Students are informed as to the purpose and procedures of health services offered/provided. | 0 | 1 | 2 | 3 | 4 |
| The school nurse and the teacher cooperate in matters pertaining to both health services and health education. | 0 | 1 | 2 | 3 | 4 |
| Health services personnel assist with teacher inservice programs. | 0 | 1 | 2 | 3 | 4 |
| Health services personnel serve as resource people in providing health instruction. | 0 | 1 | 2 | 3 | 4 |
| The teacher maintains primary responsibility for health education classes and uses resource people appropriately. | 0 | 1 | 2 | 3 | 4 |

# APPENDICES

## Oregon Revised Statutes Relating to School Health

| | |
|---|---|
| ORS 30.800 | "Good Samaritan Law" |
| ORS 109.610 | Right to treatment for venereal disease by minor without parental consent |
| ORS 109.640 | Physicians may provide birth control information to any person; right to medical or dental treatment by minors without parental consent. |
| ORS 336.185-215 | Student Records |
| ORS 336.375-420 | Dental Health Program |
| ORS 336.650 | Liability of school personnel administering medication |
| ORS 343.187 | Rules governing special education for pregnant children |
| ORS 418.740-775 | Reporting of Child Abuse |
| ORS 433.275 | Refusal to Enroll Pupil Not Complying with ORS 443.267 |
| ORS 443.263-273 (Proposed) | Immunization |

## Oregon Administrative Rules and Guidelines Relating to School Health

| | |
|---|---|
| OAR 333-21-091 to 094 | Immunization Required for Initial School Enrollment--Rules and Guidelines for the Control of Communicable Disease in Oregon |
| OAR 581-22-705 | Health Services |
| OAR 581-22-706 | Emergency Plans and Safety Programs |
| | Communicative Disorders Program Guide |

## Sample Forms

Oregon School Health Record Card

Sample Pupil Medical Record Form (goldenrod form for school entrance)

Vision Referral Worksheet (Form MCH-6)

Report on School Vision Screening (Form MCH-7)

Hearing Program Case Report (Form MCH-17)

Teacher's List of Pupils for Audiometric Tests (Form MCH-13)

Referral Form

Other

Growth Charts on Height-Weight Expectations for Children

List of recommended first aid supplies and equipment

Additional Resources

SAFETY IN OREGON SCHOOLS, Oregon Department of Education, 1980.

Note suggestions regarding emergency procedures.

CONTROL OF COMMUNICABLE DISEASE IN MAN - TWELFTH EDITION, The American Public Health Association, 1015 Eighteenth Street, NW, Washington, DC 20036.

SCHOOL HEALTH: A GUIDE FOR HEALTH PROFESSIONALS, American Academy of Pediatrics, PO Box 1034, Evanston, Illinois.

INSTRUCTIONS: KEYSORT IMMUNIZATION PROGRAM, Oregon State Health Division, Immunization Unit, 1400 SW Fifth Avenue, Portland, Oregon 97201.

IMMUNIZATION RECOMMENDATIONS, Oregon State Health Division, Immunization Unit, 1400 SW Fifth Avenue, Portland, Oregon 97201, March 1979.

OREGON ATHLETICS K-12, Oregon Department of Education, 1975.

**30.800 Liability for emergency medical assistance by medically trained persons.** (1) As used in this section:

(a) "Emergency medical assistance" means medical care not provided in a place where emergency medical care is regularly available, including but not limited to a hospital, industrial first-aid station or a physician's office, given voluntarily and without the expectation of compensation to an injured person who is in need of immediate medical care and under emergency circumstances that suggest that the giving of assistance is the only alternative to death or serious physical aftereffects.

(b) "Medically trained person" means:

(A) A person licensed under any law of a state or of the United States to practice medicine and surgery, professional nursing, osteopathy, naturopathy or chiropractic;

(B) A person who has completed successfully, within three years prior to the date on which emergency medical assistance is rendered by him, a state or federal-sponsored training program for persons engaging in the rendering of emergency medical assistance or who has completed successfully the aforesaid training program and, within three years prior to the date on which emergency medical assistance is rendered by him, regularly has engaged in the rendering of emergency medical assistance, and who possesses proof of the successful completion of such a training program;

(C) A person who has completed, within three years prior to the date on which emergency medical assistance is rendered by him, a course sponsored by the American Red Cross and is qualified to render emergency first-aid and who possesses proof of the completion of such first-aid training; and

(D) A person who, within three years prior to the date on which emergency medical assistance is rendered by him, has been trained or who has been trained and, within three years prior to the date on which emergency medical assistance is rendered by him, has served as a medical assistant or medical corpsman in the Armed Services of the United States; and

(E) A person who possesses an emergency medical technician I certificate issued pursuant to ORS 485.560 or an emergency medical technician II, III or IV certificate issued pursuant to ORS 677.610 to 677.700.

(2) No person may maintain an action for damages for injury, death or loss that results from acts or omissions of the medically trained person while rendering emergency medical assistance unless it is alleged and proved by the complaining party that the acts or omissions violate the standards of reasonable care under the circumstances in which the emergency medical assistance was rendered, if the action is against:

(a) A medically trained person; or

(b) A governmental agency or other entity which employs, trains, supervises or sponsors the medically trained person.

(3) The giving of emergency medical assistance by a medically trained person does not, of itself, establish the relationship of physician and patient or nurse and patient between the medically trained person giving the assistance and the person receiving the assistance in so far as the relationship carries with it a duty of a physician or nurse to provide or arrange for further medical care for the injured person after the giving of emergency medical assistance. [1967 c.266 §§1, 2; 1973 c.635 §1; 1979 c.576 §1; 1979 c. 731 §1]

Note: Section 2, chapter 576, Oregon Laws 1979 provides:

Sec. 2. Amendments to ORS 30.800 provided by section 1 of this Act shall not apply to any cause of action arising prior to January 1, 1980.

## RIGHTS OF MINORS

**109.610 Right to treatment for venereal disease by minor without parental consent.** (1) Notwithstanding any other provision of law, a minor who may have come into contact with any venereal disease may give consent to the furnishing of hospital, medical or surgical care related to the diagnosis or treatment of such disease, if the disease or condition is one which is required by law or regulation adopted pursuant to law to be reported to the local or state health officer or board. Such consent shall not be subject to disaffirmance because of minority.

(2) The consent of the parent, parents, or legal guardian of such minor shall not be necessary to authorize such hospital, medical or surgical care and without having given consent the parent, parents, or legal guardian shall not be liable for payment for any such care rendered. [Formerly 109.105; 1977 c.303 §1]

**109.620** [Formerly 109.115; repealed by 1973 c.827 §83]

**109.630** [1971 c.726 §1; 1973 c.454 §1; repealed by 1973 c.827 §83]

**109.640 Physicians may provide birth control information to any person; right to medical or dental treatment by minors without parental consent.** Any physician may provide birth control information and services to any person without regard to the age of such person and a minor 15 years of age or older, may give consent to hospital care, medical or surgical diagnosis or treatment by a physician licensed by the Board of Medical Examiners for the State of Oregon, and dental or surgical diagnosis or treatment by a dentist licensed by the State Board of Dental Examiners, without the consent of a parent or guardian, except as may be provided by ORS 109.660. [1971 c.381 §1]

## STUDENT RECORDS

**336.185 Definitions for ORS 336.185 to 336.215.** For purposes of ORS 44.040 and 336.185 to 336.215, the following definitions will apply:

(1) "Student records" include all records relating to students maintained by any elementary, secondary school or education service district.

(2) "Student behavioral records" are student records which include psychological tests, personality evaluations, records of conversations and any written transcript of incidents relating specifically to student behavior.

(3) "Student progress records" are student records which include transcripts of grades and courses taken, records of attendance, tests relating specifically to achievement or measurement of ability, and records of health.

(4) "Superintendent" means the highest ranking administrative officer in a school district or an educational institution, or in the absence of the superintendent, the person designated to fulfill the functions.

(5) "Board" means the board of directors of a school district or other educational institution. [1971 c.512 §1; 1979 c.274 §1]

**336.190** [Repealed by 1965 c.290 §1]

**336.195 Student records confidential; rules for inspection or release.** (1) All student records maintained by a school, educational institution or education service district shall be confidential, and except as hereinafter provided shall be open for inspection only in accordance with such rules as the board shall adopt.

(2) The board shall establish rules to provide that all student records maintained by any elementary or secondary school in the district shall be available for inspection by any parent or legal guardian requesting to see such records; however, student behavioral records shall be released only in the presence of an individual qualified to explain or interpret the records.

(3) Release of student behavioral records for use in any proceedings, civil or criminal, in any court of this state shall be made only by the superintendent or a designated representative, or with the consent of the student or juvenile so confiding or to whom such records relate, if the student is 18 years of age or over, or if the person is a minor, with the consent of the parent or legal guardian of the person. Release shall be made only in the presence of an individual qualified to explain or interpret the records.

(4) Student progress records shall be available to all teaching staff, parents, legal guardians or surrogate parents. [1971 c.512 §2; 1973 c.827 §30; 1979 c.274 §2]

**336.200** [Repealed by 1955 c.290 §1]

**336.205** [1971 c.512 §5; repealed by 1979 c.274 §4]

**336.210** [Repealed by 1955 c.290 §1]

**336.215 Transfer of student records to other schools or districts.** (1) Any school, educational institution or education service district shall transfer to any other school, educational institution or education service district all student progress records relating to a particular individual provided that they have received notice of the student enrolling in the school or institution.

(2) Any private school, as defined in ORS 345.505, must promptly transfer to any other school, educational institution or education service district all student progress records relating to a particular student upon receipt of notice of the student's enrollment in the other school or institution. [1971 c.512 §3; 1975 c.557 §11; 1979 c.274 §3]

**336.220** [Amended by 1963 c.581 §2; repealed by 1965 c.290 §1]

**336.225** [Formerly 332.340; 1965 c.100 §224; renumbered 336.035]

**336.230** [Amended by 1965 c.100 §225; renumbered 336.057]

**336.240** [Amended by 1957 c.149 §1; 1965 c.100 §226; renumbered 336.067]

**336.250** [Repealed by 1957 c.149 §2]

**336.260** [Repealed by 1965 c.100 §456]

**336.270** [Amended by 1965 c.100 §228; renumbered 336.075]

**336.280** [Repealed by 1963 c.544 §52]

**336.285** [Formerly 332.350; 1965 c.100 §231; renumbered 336.125]

**336.290** [Repealed by 1963 c.544 §52]

**336.300** [Repealed by 1963 c.544 §52]

**336.310** [Repealed by 1963 c.544 §52]

**336.320** [Repealed by 1963 c.544 §52]

**336.330** [Repealed by 1963 c.544 §52]

**336.340** [Amended by 1965 c.100 §227; renumbered 336.072]

**336.350** [Amended by 1963 c.452 §1; 1965 c.100 §222; renumbered 336.015]

**336.360** [Repealed by 1965 c.100 §456]

**336.370** [Amended by 1965 c.100 §223; renumbered 336.025]

## DENTAL HEALTH PROGRAM

**336.375 "Dental health program" defined.** As used in ORS 336.375 to 336.420, "dental health program" means a program whereby a dental examination is made at least once each school year of each pupil attending school in the district at the time of the examination and whereby dental treatment may be provided, subject to the rules of the district school board. [1965 c.100 §237]

**336.380 Dental health program authorized in districts of 100,000.** The district school board in a district with a population of 100,000 or more, according to the latest federal census, may conduct a dental health program. [Amended by 1965 c.100 §238]

**336.390 Equipment; standards; charges; consent.** (1) A district school board which conducts a dental health program may furnish necessary instruments and equipment and provide suitable quarters in which either dental examination or treatment may be made.

(2) The dental examination and treatment shall be scientific, sanitary and efficient, and may be furnished by the district school board free of expense to the minor pupils whose parents or guardians are unable to pay therefor and to the pupils who have attained the age of majority who are unable to pay therefor. Any charges made by the board for the dental examination and treatment shall be fair and reasonable.

(3) No minor pupil shall be required or permitted to receive a dental examination or treatment without the written consent of his parents or guardian. No pupil who has attained the age of majority shall be required to receive a dental examination or treatment. [Amended by 1965 c.100 §239; 1973 c.827 §31]

**336.400 Report to parent; selection of dentist; certificate of treatment.** The result of the dental examination shall be reported in writing to the parent or guardian of any pupil who, in the opinion of the person making the examination, requires dental treatment. If, after receiving the report, the parent or guardian elects to have the recommended treatment performed by a dentist of his own choosing, that dentist shall supply a certificate attesting that the treatment was performed in accordance with the report from the dental health program. The content of the certificate shall be recorded by the board. [Amended by 1965 c.100 §240]

**336.410 Nonliability for injury from treatment.** No school district shall be liable to any pupil, or to the parents or guardian of any pupil, for or on account of any claim for damage on account of any action by any person in connection with the district's dental health program. [Amended by 1965 c.100 §241]

**336.420 Cooperation and sharing expense.** Any district school board which conducts a dental health program may cooperate with and share the expense of dental examination and treatment with any other organization or individuals. [Amended by 1965 c.100 §242]

336.430 [Renumbered 336.620]

336.440 [Amended by 1965 c.100 §247; renumbered 336.610]

**336.650 Liability of school personnel administering medication.** A school administrator, teacher or other school employe designated by the school administrator, who in good faith administers medication to a pupil pursuant to written permission of the pupil's parents or guardian and in compliance with the instructions of a physician, is not liable in a criminal action or for civil damages as a result of the administration except for an act or omission amounting to negligence or wilful and wanton misconduct. [1979 c.363 §2]

336.990 [Amended by 1963 c.544 §60; subsection (4) of 1963 Replacement Part derived from 332.990 (7); repealed by 1965 c.100 §456]

**343.187 Rules governing special education for pregnant children.** In addition to any other rules which may be adopted pursuant to ORS 343.155, the Department of Education shall establish by rule procedures for considering and obtaining special education for pregnant children. Such rules shall include, but not be limited to, the obligation of the school district to:

(1) Inform pregnant students and their parents of the students' rights to special educational services under this section and the availability of such services in the school district or education service district;

(2) Facilitate the provision of related services, including counseling, to pregnant students; and

(3) Inform pregnant students and their parents of the availability of resources provided by other agencies, including health and social services. [1979 c.423 §14 (enacted in lieu of 343.077)]

343.190 [Repealed by 1965 c.100 §456]

## REPORTING OF CHILD ABUSE

**418.740 Definitions for ORS 418.740 to 418.775.** As used in ORS 418.740 to 418.775, unless the context requires otherwise:

(1) "Abuse" means:

(a) Any physical injury to a child which has been caused by other than accidental means, including any injury which appears to be at variance with the explanation given of the injury.

(b) Neglect which leads to physical harm. A child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for this reason alone, not be considered a neglected child within the meaning of ORS 418.740 to 418.775 and 419.476.

(c) Sexual molestation.

(2) "Child" means an unmarried person who is under 18 years of age.

(3) "Public or private official" means:

(a) Physician, including any intern or resident.

(b) Dentist.

(c) School employe.

(d) Licensed practical nurse or registered nurse.

(e) Employe of the Department of Human Resources, county health department, community mental health program, a county juvenile department, or a licensed child-caring agency.

(f) Peace officer.

(g) Psychologist.

(h) Clergyman.

(i) Social worker.

(j) Optometrist.

(k) Chiropractor.

(L) Certified provider of day care, foster care, or an employe thereof.

(m) Attorney.

(n) Naturopathic physician.

(4) "Law enforcement agency" means:

(a) Any city or municipal police department.

(b) Any county sheriff's office.

(c) The Oregon State Police.

(d) A county juvenile department. [1971 c.451 §2; 1973 c.408 §32; 1975 c.644 §2; 1979 c.731 §4]

**418.745 Policy.** The Legislative Assembly finds that for the purpose of facilitating the use of protective social services to prevent further abuse, safeguard and enhance the welfare of abused children, and preserve family life when consistent with the protection of the child by stabilizing the family and improving parental capacity, it is necessary and in the public interest to require mandatory reports and investigations of abuse of children. [1971 c.451 §1; 1975 c.644 §3]

**418.750 Duty of officials to report child abuse; exception for privileged communications.** Any public or private official having reasonable cause to believe that any child with whom he comes in contact in his official capacity has suffered abuse, or that any adult with whom he comes in contact in his official capacity has abused a child shall report or cause a report to be made in the manner required in ORS 418.755. Nothing contained in ORS 44.040 shall affect the duty to report imposed by this section, except that a psychiatrist, psychologist, clergyman or attorney shall not be required to report information communicated to him by an adult if the communication is privileged under ORS 44.040. [1971 c.451 §3; 1973 c.110 §2; 1975 c.644 §4]

**418.755 Report content; notice of report to law enforcement agencies and local Children's Services Division office.** An oral report shall be made immediately by telephone or otherwise to the local office of the Children's Services Division or to a law enforcement agency within the county where the person making the report is at the time of his contact. If known, such reports shall contain the names and addresses of the child and his parents or other persons responsible for his care, the child's age, the nature and extent of the abuse (including any evidence of previous abuse), the explanation given for the abuse and any other information which the person making the report believes might be helpful in establishing the cause of the abuse and the identity of the perpetrator. When a report is received by the Children's Services Division the division shall immediately notify a law enforcement agency within the county where the report was made. When a report is received by a law enforcement agency, the agency shall immediately notify the local Children's Services Division within the county where the report was made. [1971 c.451 §4; 1975 c.644 §7; 1977 c.741 §1]

**418.760 Duty of division or law enforcement agency receiving report; investigation; protective services for child.** (1) Upon receipt of oral report required under ORS 418.750, the Children's Services Division or the law enforcement agency shall immediately cause an investigation to be made to determine the nature and cause of the abuse of the child.

(2) If the law enforcement agency conducting the investigation finds reasonable cause to believe that abuse has occurred, the law enforcement agency shall notify in writing the local office of the Children's Services Division. The Children's Services Division shall provide protective social services of its own or of other available social agencies if necessary to prevent further abuses to the child or to safeguard his welfare.

(3) If protective social services are provided, the division shall promptly make reasonable efforts to ascertain the name and address of the child's parent or guardian. If the name and address can be ascertained, the division shall notify the parent or guardian that the child is in protective custody. [1971 c.451 §5; 1975 c.644 §8; 1977 c.741 §2]

**418.762 Immunity of persons making reports in good faith.** Anyone participating in good faith in the making of a report pursuant to ORS 418.750 to 418.760 and who has reasonable grounds for the making thereof, shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed with respect to the making or content of such report. Any such participant shall have the same immunity with respect to participating in any judicial proceeding resulting from such report. [1975 c.644 §6]

**418.764 Photographing child during investigation; photographs as records.** (1) In carrying out its duties under ORS 418.760, any law enforcement agency or the Children's Services Division may photograph or cause to have photographed any child subject of the investigation for purposes of preserving evidence of the child's condition at the time of the investigation.

(2) For purposes of ORS 418.770, photographs taken under authority of subsection (1) of this section shall be considered records. [1977 c.97 §2]

**418.765 Central registry of reports.** A central state registry shall be established and maintained by the Children's Services Division. The local offices of the Children's Services Division shall report to the state registry in writing when investigation has shown that the child's condition was the result of abuse even if the cause remains unknown. Each registry shall contain information from reports catalogued both as to the name of the child and the name of the family. [1971 c.451 §6; 1973 c.306 §1; 1975 c.644 §9; 1977 c.741 §3]

**418.770 Confidentiality of records; availability to law enforcement agencies and physicians.** (1) Notwithstanding the provisions of ORS 192.001 to 192.500 and 192.610 to 192.990 relating to confidentiality and accessibility for public inspection of public records and public documents, reports and records compiled under the provisions of ORS 418.750 to 418.762 and 418.765 are confidential and are not accessible for public inspection. However, the Children's Services Division shall make records available to any law enforcement agency or a child abuse registry in any other state for the purpose of subsequent investigation of child abuse, and to any physician, at his request, regarding any child brought to him or coming before him for examination, care or treatment.

(2) Any record made available to a law enforcement agency in this state or a physician in this state, as authorized by subsection (1) of this section, shall be kept confidential by the agency or physician.

(3) No officer or employe of the Children's Services Division, any social service agency, any law enforcement agency or any physician shall release any information not authorized by subsection (1) of this section. [1971 c.451 §7; 1973 c.306 §2; 1975 c.644 §10; 1977 c.741 §4]

**418.775 Certain privileges not grounds for excluding evidence in court proceedings on child abuse.** (1) In the case of abuse of a child, as defined in ORS 418.740, the physician-patient privilege, the husband-wife privilege, and the privilege extended to staff members of schools and to nurses under ORS 44.040 shall not be a ground for excluding evidence regarding a child's abuse, or the cause thereof, in any judicial proceeding resulting from a report made pursuant to ORS 418.750.

(2) In any judicial proceedings resulting from a report made pursuant to ORS 418.750, either spouse shall be a competent and compellable witness against the other. [Formerly 146.770; 1973 c.110 §1; 1975 c.644 §11]

**433.275 Refusal to enroll pupil not complying with ORS 433.267.** The school administrator of any school at which a pupil applies for enrollment without meeting the requirements of ORS 433.267 shall refuse to enroll the pupil until the requirements are met. [1973 c.566 §5]

# IMMUNIZATION

ORSs 433.263, 433.255, 433.260, 433.267, 433.269 and 433.273 presented below represent the versions before the Oregon Legislative Assembly, 1981 Regular Session, as of March 6, 1981; they were current as of the publication of these guidelines.

SUMMARY of House Bill 2139, March 6, 1981: "Revises procedures for mandatory immunization for school children and children in day care facilities caring for six or more children. Requires local health departments to offer immunization clinic in each high school attendance area prior to August 15, 1982."

## 433.263

As used in ORS 433.255 to 433.273:

(1) "Administrator" means the principal or other person having general control and supervision of a school or certified day care facility.

(2) "Certified day care facility" or "facility" means a day care facility caring for six or more children and certified pursuant to ORS 418.805 to 418.885.

(3) "Local health department" or "department" means the district or county board of health, public health officer, public health administrator or health department having jurisdiction within the area.

(4) "Parent" means a parent or guardian of a child or any adult responsible for the child.

(5) "Physician" means a physician licensed by the Board of Medical Examiners for the State of Oregon or by the Naturopathic Board of Examiners or a physician similarly licensed by another state in which the physician practices or a commissioned medical officer of the Armed Forces or Public Health Service of the United States.

(6) "School" means a public, private or parochial school.

## 433.255

Except in strict conformity with the rules of the Health Division, no child or employe shall be permitted to be in any school or facility when:

(1) Afflicted with any communicable disease or condition;

(2) From any house in which exists any communicable disease or condition; or

(3) A child has been excluded as provided in ORS 433.267(5).

### 433.260

(1) Whenever any administrator has reason to suspect that any child or employe is afflicted with or has been exposed to any communicable disease or condition required by the rules of the Health Division to be excluded from a school or facility, the administrator shall send such person home and report the occurrence to the local health department by the most direct means available.

(2) Any person excluded under subsection (1) of this section shall not be permitted to be in the school or facility until the person presents a certificate from a physician stating that the person is not afficted with nor a carrier of any communicable disease or condition.

### 433.267

(1) As a condition of attendance in any school or facility in this state, every child through grade 12 shall submit to the administrator one of the following statements unless the school or facility which the child attends already has on file a record which indicates that the child has received immunizations against the communicable diseases prescribed by rules of the Health Division as provided in ORS 433.273:

(a) A statement signed by the parent certifying that the child has received immunizations against the communicable diseases prescribed by rules of the Health Division as provided in ORS 433.273;

(b) A statement signed by the parent, a practitioner of the healing arts who has within the scope of the practitioner's license the authority to administer immunizations or a representative of the local health department that describes the manner in which the child has begun the immunization process as prescribed by rules of the Health Division pursuant to ORS 433.273;

(c) A statement signed by a physician or a representative of the local health department that the child should be exempted from receiving specified immunization because of indicated medical diagnosis;

(d) A statement signed by the parent that the child has not been immunized as described in paragraph (a) of subsection (1) of this section because the child is being reared as an adherent to a religion the teachings of which are opposed to such immunization; or

(e) A statement signed by the parent of a child transferring to a school or facility from another school district of facility that the parent will have records required by paragraphs (a) to (d) of this subsection for the child sent to the school or facility within 30 days of initial enrollment of the child therein.

(2) Children who have been emancipated pursuant to ORS 109.565 or who have reached the age of majority as provided in ORS 109.510 may sign those statements on their own behalf otherwise requiring the signatures of parents under subsection (1) of this section.

(3) The administration shall conduct a primary evaluation of the records previously on file or newly submitted pursuant to subsection (1) of this section to determine whether the child is entitled to enroll or continue in attendance by reason of having submitted a statement that complies with the requirements of subsection (1) of this section.

(4) If the records do not comply or are not received within 30 days as provided in paragraph (e) of subsection (1) of this section, the administrator shall notify the local health department and shall transmit any records concerning the child's immunization status to the department.

(5) The department shall provide for a secondary evaluation of the records to determine whether the child should be excluded for noncompliance with the requirements stated in paragraph (a) or (e) of subsection (1) of this section. If the child is determined to be in noncompliance, the department shall issue an exclusion order and shall send copies of the order to the parent and the administrator. On the effective date of the order, the administrators shall exclude the child from the school or facility and not allow the child to attend the school or facility until the requirements of this section have been met.

(6) The administrator shall readmit the child to the school or facility when in the judgment of the local health department the child is in compliance with the requirements of this section. The department shall return the records of the child who has been readmitted to the appropriate school or facility.

(7) The administrator shall be responsible for updating the statement described in paragraph (b) of subsection (1) of this section as necessary to reflect the current status of the immunization of the child and the time at which the child comes in to compliance with immunization against the communicable diseases prescribed by rules of the Health Division pursuant to ORS 433.273.

(8) Nothing in this section shall be construed as relieving agencies, in addition to school districts, which are involved in the maintenance and evaluation of immunization records on the effective date of this 1981 Act from continuing responsibility for these activities.

(9) All statements required by this section shall be on forms approved or provided by the Health Division.

433.269

(1) Local health departments shall make available immunizations to be administered under the direction of the local health officer in convenient areas. No child shall be refused service because of inability to pay.

(2) The local health department, and all schools and facilities shall report annually to the Health Division as specified in the rules of the Health Division on the number of children in the area served who are susceptible to communicable disease by reason of noncompliance. A child exempted under ORS 433.267 shall be considered to be susceptible.

(3) The local health department shall maintain records of children who are excluded from schools and facilities. Schools and facilities shall maintain records of children in attendance conditionally because of incomplete immunization schedules and children exempted under ORS 433.267.

433.273

The Health Division shall adopt rules pertaining to the implementation of ORS 433.255 to 433.273, which shall include, but need not be limited to:

(1) The required immunization against diseases, including rubella, considered to be dangerous to the public health under ORS 433.267:

(2) The time schedule for immunization;

(3) The approved means of immunization;

(4) The procedures whereby students may be excluded from attendance in schools or facilities, including service of notice to parents; and

(5) The manner in which immunization records for children are established, evaluated and maintained.

SECTION 8.

(1) The Assistant Director for Health shall appoint a committee to advise the Health Division on the administration of the provisions of ORS 433.255 to 433.273, including the adoption of rules pursuant to ORS 433.269(2), 433.273 and sections 12 and 14 of this 1981 Act.

(2) Members of the committee appointed pursuant to subsection (1) of this section shall include, but need not be limited to, representatives of the Health Division, the Department of Education, public, private and parochial schools, education service districts, certified day care facilities, local health departments, the boards of county commissioners or county courts and the public.

SECTION 9.

In adopting this 1981 Act, the Legislative Assembly recognizes the obligation of parents to have their children properly immunized and to provide to schools and facilities accurate records of immunization.

SECETION 10.

Notwithstanding ORS 339.030(8), nothing in ORS 433.255 to 433.273 operates to remove parental liability under compulsory attendance laws.

SECTION 11.

Nothing in ORS 179.505, 192.525, 192.530 or 336.185 to 336.215 operates to prevent:

(1) Inspection by or release to administrators by local health departments of information relating to the status of a child's immunization against communicable diseases without the consent of the child or the parent.

(2) Local health departments from releasing information concerning the status of a child's immunization against communicable diseases by telephone to the parent, administrators and public health officials.

SECTION 12.

Local health departments shall offer at least one immunization clinic in each high school attendance area or other area convenient to the students and agreeable to the affected departments, school districts and facilities prior to the date of implementation as provided in section 14 of this Act. No child shall be refused service at such clinics because of inability to pay.

SECTION 13.

Notwithstanding ORS 431.170(2), during the 1981-1983 biennium, the Health Division shall provide free of charge to local health departments:

(1) The necessary resources in personnel and supplies for the implementation of ORS 433.255 to 433.273, if a department is financially unable to do so and requests the assistance of the Health Division; and

(2) Vaccines required for the implementation of ORS 433.255 to 433.273.

SECTION 14.

The provisions of ORS 433.267(5) shall be implemented as soon as practicable, in accordance with rules adopted by the Health Division, but in no case later than August 15, 1982.

SECTION 15.

ORS 433.275 is repealed on August 15, 1982.

## COMMUNICABLE DISEASES

333-21-091

Immunizations are required against the following diseases:

(1) Poliomyelitis (Polio)
(2) Measles (Rubeola)
(3) Diphtheria
(4) Pertussis (Whopping Cough)*
(5) Tetanus (Lockjaw)
(6) Rubella (German Measles)

*Not required to be given to those seven years of age or older.

## RECOMMENDED OPTIMUM IMMUNIZATION SCHEDULE

333-21-092

(1) DTP, a combined vaccine for diphtheria, tetanus, and pertusis (whooping cough), should be given initially in a series of three innoculations at the ages of two, four, and six months. A reinforcing dose should be given at 15-18 months of age and again between 48 months and just prior to initial school entry.

(2) Initial immunization against poliomyelitis should consist of two doses of oral trivalent vaccine, one at the age of two months and the second at four months. Reinforcing doses of trivalent vaccine should be given at the age of 15-18 months and at between four years and just prior to initial school entry.

(3) Measles vaccine (live virus, attenuated) should be given at the age of 15 months.

(4) Rubella vaccine (live virus, attenuated) should be given at the age of 12-15 months.

(5) If combination Measles, Mumps, Rubella vaccine is to be given, it should be given at 15 months of age and Rubella deferred to that time.

(6) The foregoing is summarized in the following schedule:

| AGE IN MONTHS | IMMUNIZATIONS |
|---|---|
| 2 | DTP and Polio |
| 4 | DTP and Polio |
| 6 | DTP |
| 12-15 | Rubella |
| 15 | Measles or Combination Measles, Mumps, Rubella |
| 15-18 | DTP, Polio boosters* |

---

*Same boosters prior to initial school entry.

## REQUIRED IMMUNIZATION SCHEDULE

333-21-094

Compliance with the following shall be determinative of a child's eligibility for enrollment in school under ORS 433.263 to 433.275.

(1) Schedule of minimum requirements:

| AGE | VACCINE | NUMBER OF DOSES |
|---|---|---|
| Through 6 | DTP | 5 |
| | Polio | 4 |
| | Measles | 1 |
| | Rubella | 1 |
| 7 - 14 | Td (after 6 years) | 2 |
| | Polio | 3 |
| | Measles | 1 |
| Boys 5 - 14<br>Girls prepubertal only | Rubella | 1 |

(2) Exceptions may be made to the requirements in subsection (1) for DTP, Polio, and Td if (a) the child started immunization late and reinforcing doses are not due under his personal immunization schedule or (b) the child is over 6 years of age and because of prior DTP doses a lesser amount of Td would suffice. The Local Health Department or Physician can determine such exceptions.

(3) Medically diagnosed and documented diphtheria, pertussis, and measles, but not poliomyelitis and rubella, will be considered the equivalent of vaccination for these specific diseases.

(4) Trivalent Oral Polio Vaccine is the State Health Division's vaccine of choice, but inactivated polio vaccine may be substituted in the appropriate dosage.

## IMMUNIZATION SCHEDULES FOR THE DISEASES OF CHILDREN

The Oregon State Health Division was authorized to develop immunization standards required for school entry. The Health Division is in agreement with the following immunization standards of the American Academy of Pediatrics.

## GUIDELINES

### IMMUNIZATION SCHEDULE STANDARDS

For Children Starting Immunization in Early Infancy

| | | |
|---|---|---|
| 2 months | DTP[1] | TOPV[2] |
| 4 months | DTP | TOPV |
| 6 months | DTP | ——[3] |
| 1 year | | Tuberculin Test[4] |
| 15 months | Measles[5], Rubella | Mumps |
| 1-1/2 years | DTP | TOPV |
| 4-6 years | DTP | TOPV |
| 14-16 years | Td[6]--repeat every 10 years | |

For Children not Immunized in Early Infancy but Starting Before the Sixth Birthday

| | |
|---|---|
| First Visit | DTP, TOPV, Tuberculin Test |
| Interval after first visit | |
| 1 month | Measles[5], Mumps, Rubella |
| 2 months | DTP, TOPV |
| 4 months | DTP, TOPV |
| 10 to 16 months or preschool | DTP, TOPV |
| Age 14-16 years | Td--repeat every 10 years |

For Children Starting After the Sixth Birthday

| | |
|---|---|
| First Visit | Td, TOPV, Tuberculin Test |
| Interval after first visit | |
| 1 month | Measles, Mumps, Rubella |
| 2 months | Td, TOPV |
| 8 to 14 months | Td, TOPV |
| Age 14-16 years | Td--repeat every 10 years |

1 DTP. . .Diptheria and tetanus toxoids combined with pertussis vaccine.
2 TOPV . .Trivalent oral poliovirus vaccine. This recommendation is suitable for breast-fed as well as bottle-fed infants.
3 . . . .This is changed. A third dose of TOPV is now optional but may be given in areas of high endemicity of poliomyelitis.
4 . . . .Frequency of repeated tuberculin tests depends on risk of exposure of the child and on the prevalence of tuberculosis in the population. In view of the low prevalence of positive tuberculin tests in Oregon high school students, the Oregon Health Division recommends that testing be done routinely at one year of age and be repeated only when exposure is suspected. The initial test should be done at the time of or preceding the measles immunization.
5 . . . .This is changed from the last "Redbook." Measles should be given at 15 months and may be given as measles-rubella or measles-mumps-rubella combined vaccines.
6 Td . . .Combined tetanus and diphtheria toxoids. This is the adult type for persons older than 6 years of age, in contrast to diphtheria-tetanus (DT) toxoids which contain a larger amount of diphtheria antigen.
Tetanus toxoid at time of injury: For clean, minor wounds, no booster dose is needed by a fully immunized child unless more than 10 years have elapsed since the last dose. For contaminated wounds, a booster dose should be given if more than 5 years have elapsed since the last dose.
7 . . . .Optional.

## CATCH-UP IMMUNIZATION GUIDELINES

How does one complete a course of vaccinations in a child whose unfinished immunization history bears no resemblance to the recommended schedule? The purpose of these guidelines is to provide a reasonable course of action which will promote immunity without excessive use of vaccine. There is no single best way to conduct catch-up immunizations. Some physicians may prefer equally sound methods which differ from this one.

### THE BASIC PRINCIPLE

The basic principle to follow in administering vaccine to partially immunized children is to complete the series as outlined in the recommended schedules. Of primary importance is that the child receive the appropriate total number of recommended doses of vaccine. The timing of doses is significant, but under the circumstances of catch up immunization, timing is of secondary importance.

### FOR CHILDREN PRESENTING BEFORE THEIR SIXTH BIRTHDAY+

### DTP

Tetanus and diphtheria toxoids are very immunogenic. A primary series of three doses can induce antibodies against these two diseases, which have significant morbidity and mortality for any age group. On the other hand, pertussis has greatest morbidity and mortality during the first few years of life. Pertussis vaccine is poorly immunogenic and protects for a much shorter period of time.

This is why DTP is given so often during early childhood. Pertussis vaccine also can have undesirable side effects in older age groups who do not need the protection. This is the basis for recommending DTP before the sixth birthday+ and Td after the sixth birthday.+ Furthermore, because of the need to give pertussis vaccine more often, four or five DTP doses are given to the younger age groups whereas only three TD doses are a sufficient primary series in the older child who does not require pertussis vaccine.

To initiate DTP vaccination at school entry for the child with no prior dose, give four doses according to the schedule in Table 2.

To complete DTP vaccination at school entry for the child who has previously been given one or more doses of DTP vaccine, use Table 2 as a guide and finish the series as illustrated by the following examples:

> If the child has received ONE dose of DTP at any age previously, he or she should have three more doses of vaccine: one now, a second two months later, and a third after at least six more months (optimally in one year).
>
> If the child has received TWO doses of DTP at any previous time, he or she should have two more doses of vaccine: one now and the second dose after at least six more months (optimally in one year).
>
> If the child has received THREE doses of DTP at any previous time, he or she should have a booster dose of vaccine now provided that at least six months have elapsed since the last dose (optimally after more than one year).

Barring previous allergy or hypersensitivity to DTP, the child should be given DTP vaccine up until the sixth birthday.+ After the sixth birthday, doses should be given only as Td and according to the schedule in Table 3--i.e., three doses of diphtheria and tetanus toxoids appropriately spaced are sufficient for a primary series.

## POLIO

Protection against polio is considered to be completion of a primary series plus a booster dose of vaccine when indicated. (NOTE that the four month dose in Table 2 is optional.)

A primary series consists of three doses of TOPV with the first two doses given at not less than six weeks (preferably eight weeks) apart and followed by a third dose which is given preferably eight to twelve months later. This third dose may be given sooner (at least two months after the second dose) to complete the primary series if there is doubt that the child will return in a year. Primary immunization under these circumstances (two month interval) may not afford as reliable protection as the primary series which includes a longer interval between the second and third doses.

Booster doses are recommended only in two circumstances. One is at the time of school entry. The purpose here is to pick up (1) the two to five percent of children with optimal primary immunization who did not develop immunity to one or more types of polio virus and (2) those children who may not have had optimal spacing between the doses of the primary series. The second indication for a booster dose is high risk of exposure to wild poliovirus.

To initiate polio vaccination at school entry for the child with no prior dose, follow the schedule in Table 2 for the primary series. A booster dose is not necessary for a child who is completing the primary series at school entry.

> If the child has received ONE dose of TOPV previously, the primary series should be completed: a second dose now and a third dose one year later.*
>
> If the child has received TWO doses of TOPV previously, the primary series should be concluded with a third dose now.*
>
> If the child has received THREE doses of TOPV at any time previously, the complete immunization should include a booster dose now provided that at least eight months have elapsed since the last dose.

### FOR CHILDREN PRESENTING AFTER THEIR SIXTH BIRTHDAY+

Children who are six and older who did not receive any Polio or Td (or DTP) vaccine until after the sixth birthday+ should complete the series in a similar manner and according to the schedule in Table 3.

Children who are six and older and who received any DTP vaccine before their sixth birthday,+ should complete the series with Td as outlined above using Table 3 and counting each previous DTP dose as equivalent to a Td dose. Td vaccine should be given regardless of whether or not immunizations had been started with DTP, DT, or Td.

---

+The official recommendation of the ACIP# is that DTP should be given until the seventh birthday. The "Redbook"@ defines the cutoff to be six years of age. Although it's probably appropriate to give DTP up to the seventh birthday, many physicians and health departments in Oregon use the "Redbook" guideline. For the purpose of a definition here, we are referring to this cutoff as the sixth birthday.

*The third dose should be scheduled for eight to twelve months after the second dose if one is certain that the child will return. If it seems likely that the child will not return, then the third dose can be given two months after the second dose. There may be some reduction in the protection rate with the shorter time period.

#ACIP--Advisory Committe on Immunization Practice--U.S. Public Health Service.

@"Redbook"--Report of the Committee on Infectious Diseases American Academy Pediatrics.

## COMMMON COMMUNICABLE DISEASES
## RECOMMENDED GUIDELINES FOR THE SCHOOL

| DISEASE | SYMPTOMS | INCUBATION | PERIOD OF COMMUNICABILITY | EXCLUSION | PREVENTATIVE MEASURES |
|---|---|---|---|---|---|
| Abscesses | See Boils | | | | |
| Athletes Foot (Fungus) | Dry scaling and/or cracking blisters, and itching, especially between toes | Unknown | As long as signs and symptoms are present | None | - clean, dry feet & socks<br>- use own towels & socks<br>- routine disinfection of school showers<br>- recommend use of thongs in showers |
| Boils | A large pimple-like sore, swollen, red, tender, may be crusted or draining | Variable, commonly 4 - 10 days | While draining | Exclude - return with physician's permit or after draining ceases | - good hygiene<br>- must not handle food while lesion present |
| Chickenpox | Rash in thin-walled easily ruptured blisters - heaviest on trunk | 10 - 20 days (average 12-15) | 5 days before rash to 6 days after last eruption | Exclude immediately, return with permit or when scabs are healed | - good hand washing<br>- cover mouth when coughing |
| Common Cold | Runny nose and eyes, cough, sneezing, possibly a sore throat | 12 - 72 hours | 5 days after first symptoms | | - hand washing<br>- cover mouth when coughing<br>- good nutrition & rest |
| Hepatitis | Upper right abdominal tenderness, nausea, fatigue, loss of appetite, jaundice, myalgia, fever | Acute: "Infections/ "A" 15 - 50 days | 2 weeks before jaundice symptoms | Exclude immediately - return with physician's permit | - must not handle food if Hepatitis "A"<br>- scrupulous hand washing after using the bathroom<br>- clean toilet facilities<br>- gama for close contacts |
| | | "Serum"/"B" 45 - 160 days | Variable | | |
| Impetigo | Sores (often around the mouth and nose) crusted, draining, itching | 1 - 3 days | Long as sores drain from 10 - 21 days if untreated | Exclude, return with permit or when lesions are dry | - clean, short (finger-nails)<br>- good hygiene<br>- avoid scratching |
| Influenza "Flu" | Fever, chills, headaches, myalgia, coryza, cough, sore throat | 24 - 72 hours | 3 days after onset | Exclude until acute symptoms are gone | - avoid crowds<br>- good hand washing<br>- covering mouth on cough<br>- good nutrition & rest<br>- vaccine for high-risk persons |
| Lice (Head) | Lice and/or nits (small white eggs) in the hair | 1 - 2 weeks | As long as lice and nits are alive - until treated | Exclude all family members, return with written statement from parent that child has been treated | - treat entire family<br>- avoid sharing hats, combs<br>- good hygiene<br>- inspect heads during breakout |

| DISEASE | SYMPTOMS | INCUBATION | PERIOD OF COMMUNICABILITY | EXCLUSION | PREVENTATIVE MEASURES |
|---|---|---|---|---|---|
| Mononuclosis | Fever, sore throat, swollen neck glands, fatigue | 2 - 6 weeks | Unknown | Return with permit | - avoid shared eating utensils and food<br>- good dish washing technique |
| Measles (Rubeola or "10-day measles") | Fever, conjunctivitis, runny nose, a very harsh cough; 3 - 7 days later dusky red rash (starts at hairline and spreads down); white spots in mouth | 8 - 14 days | Onset of symptoms to 4 days after rash begins | Exclude - return with permit or 5 days after rash begins | - immunization<br>- good hygiene<br>- cover mouth when coughing |
| Mumps | Painful swelling of neck glands, fever | 12-26 days | 2 - 6 days before swelling to 9 days after symptoms | Exclude - return with permit or until swelling subsides | - immunization<br>- cover mouth when coughing<br>- avoid sharing eating utensils |
| Pink Eye | Eyes reddened - may be purulent discharge | 1 - 3 days | Can be very contagious as long as drainage present | Exclude - see physician - return with permit | - good hand washing technique<br>- avoid serving food<br>- good hygiene, avoid rubbing eyes |
| Ringworm | Scalp: gray, scaling bald patches<br>Body: reddish skin ring (itches) | 10-14 days<br>10 - 14 days | Variable - treatment may be prolonged | Exclude - return with permit | - avoid sharing combs, towels, hats<br>- check pets for loss of hair<br>- good hygiene<br>- during outbreaks, examine heads |
| Rubella | Mild coryza, conjunctivitis, possible headache, malaise, low fever; pinkish rash that starts at face and spreads rapidly to trunk and limbs. (Fades in 3 days) | 14 - 21 days (average 18) | 1 week before and up to 4 days after rash begins | Exclude - return with permit or 5 days after rash begins | - immunize<br>- cover mouth when coughing |
| Scabies | Caused by small mite that burrows under skin leaving small red or dark lines. (1/8"-1/4") Common hands, especially between fingers - itching severe | Variable | Until medically treated - all family members should be treated | Exclude all family members when symptoms noted - return with permit | - good hygiene |
| Scarlet Fever (a complication of Strep Throat) | Onset: Symptoms - fever, nausea, sore throat, headache; About 2nd day Rash: red, blotchy, sandpapery, not on face, "strawberry" tongue | 1 - 3 days | Variable | Exclude - return with permit or after 10 days | - good hygiene<br>- cover mouth when coughing |
| Pinworms | Nervousness, "hyper," itching of anus (especially at night); worms in stool | Variable 3 - 6 weeks or more | Until medically treated (recommend treatment of whole family) | None | - daily bathing<br>- clean underclothing and bed linens<br>- wash hands and under fingernails (to avoid reinfecting self)<br>- short nails |

## Health Services

**581-22-705** (1) The school district shall maintain a prevention-oriented health services program for all students which provides:

(a) Emergency health care, including space separated from other students adequately equipped for providing first aid;

(b) Communicable disease control, as provided in Oregon Revised Statutes;

(c) Health records and health record information;

(d) Adaptation of services for students with special health needs;

(e) Coordination with the health education program; and

(f) Vision and auditory screening.

(2) School nurses employed by a school district shall be licensed to practice as registered nurses.

### Compliance Indicators

- The district maintains a prevention-oriented health services program for all students.
- The program provides for:
  - — emergency health care and separate space for providing first aid,
  - — control of communicable disease,
  - — health records and health record information kept on all students,
  - — services for students with special health needs,
  - — coordination with the health education program, and
  - — vision and auditory screening.
- The school district only employs school nurses who have licenses to practice as registered nurses.

### Commentary

The intent of the health services standard is to assist school districts in designing programs which will assure that minimal health needs of students are met. Teacher involvement in prevention-oriented health services is essential to the success of the program. A child who is in poor health is less able to benefit from the educational program or, in some instances, a child may have a communicable disease which endangers others. Health services include procedures required by law, as well as procedures which prevent health problems, such as good recordkeeping, adaptation of services for special needs, and coordination with the school health education program.

This standard requires that a separate space under proper supervision be provided for ill or injured children. In small schools, this requirement can be met by placing a bed or cot in the principal's office or adjacent room where ill or injured children may lie down. Having these children sit in the main office where others frequently pass should be avoided.

## Emergency Plans and Safety Programs

**581-22-706** The school district shall maintain a comprehensive safety program for all employes and students which shall:

(1) Include plans for responding to emergency situations;

(2) Specify general safety and accident prevention procedures with specific instruction for each type of classroom and laboratory;

(3) Provide instruction in basic emergency procedures for each laboratory, shop and studio, including identification of common physical, chemical, and electrical hazards;

(4) Require necessary safety devices and instruction for their use;

(5) Require that an accident prevention inservice program for all employes be conducted periodically and documented;

(6) Provide assurance that each student has received appropriate safety instruction;

(7) Provide for regularly-scheduled and documented safety inspections which will assure that facilities and programs are maintained and operated in a manner which protects the safety of all students and employes; and

(8) Require reports of accidents involving school district property, or involving employes, students or visiting public, as well as prompt investigation of all accidents, application of appropriate corrective measures, and monthly and annual analyses of accident data and trends.

**Compliance Indicators**

- The school district maintains a comprehensive safety program to assure that:
  - — a plan is available to respond to emergency situations;
  - — general safety and accident prevention procedures are provided for each type of classroom and laboratory;
  - — instruction is provided in basic emergency procedures for each laboratory, shop and studio, including common physical, chemical and electrical hazards;
  - — necessary safety devices and instruction for their use are provided;
  - — an accident prevention inservice program is conducted and periodically documented;
  - — students receive appropriate safety instruction;
  - — safety inspections are scheduled and conducted regularly of all district property, and documentation is available of these inspections;
  - — reports of accidents involving school district property, employes, students or the visiting public are made promptly; and
  - — all accidents are investigated and appropriate corrective measures implemented.
- The district conducts monthly and annual analyses of accident data and trends.

**Commentary**

This standard requires that districts establish safety and emergency procedures to provide for emergency health care, safety and accident prevention, as well as the availability of proper safety equipment and instruction on its use. Procedures also should require that regular safety inspections be made and documented. In addition, regular inservice programs and data analyses should be conducted to ensure that facilities and educational programs are maintained and operated in a manner which would minimize or prevent accidents.

71

# COMMUNICATIVE DISORDERS PROGRAM
# GUIDE

Oregon State Health Division
Office of Community Health Services
Maternal and Child Health Section

Telephone: 229-5776

Address: 520 SW 6th Avenue
PO Box 231
Portland, OR 97207

## PURPOSE AND FUNCTIONS OF PROGRAM

The primary purpose of the Hearing Conservation Program is early recognition of decreased hearing sensitivity in the preschool and school-age child. Identifying children who have impaired hearing and bringing these children to the attention of their parents and subsequently to the physician for diagnosis and necessary care is the basic function of the Hearing Conservation Program.

## ORGANIZATION OF THE PROGRAM

Group Screening:

Screening is done each year by the State Health Division audiometrists in kindergartens and the odd numbered grades, through 5th grade, in all schools throughout the State. Children in even numbered grades who show evidence of ear disease, who are suspected or having a previously undiagnosed hearing impairment or who are new to the State may be tested through teacher-nurse referrals. The Johnston group screening test is used to efficiently screen large numbers of children as it accommodates ten children at one time. Four pure tones are presented at a level of about 20 decibels. Frequencies tested are 1000, 2000, 4000, and 6000 Hz. If a child fails to respond to any one frequency in either ear, he is given an individual air conduction threshold test.

Individual Audiometric Testing:

Air conduction thresholds are determined for children for the six frequencies 500, 1000, 2000, 3000, 4000, and 6000 Hz. The three lower frequencies and the three higher frequencies are averaged separately for each ear. Basis for referrals for further audiological screening is an average impairment of 20 dB or greater in the lower frequencies and 25 dB or greater in the higher frequencies in either ear.

Computer Record and Audiogram Screening:

The audiogram and the child's computer record are examined to determine the need for further diagnostic evaluation. Children are deferred from further diagnostic testing for the following reasons:

(1) Child has a low tone loss.

(2) Child has a high tone loss.

(3) Child is currently under medical care.

(4) Child has known sensorineural hearing loss.

Further diagnosis evalutions are completed in one of two ways. Either the child is referred to a county otology clinic or he/she will be retested in the school.

Follow-up School Audiological Evaluations:

In the larger counties, children requiring further diagnostic evaluations are retested in the schools. Retest evaluations usually occur in a four to six week period after the initial hearings screening. Audiological testing consists of the following tests:

(1) Pure tone air conduction test for the frequencies 500, 1000, 2000, 3000, 4000 and 6000 Hz., for both ears.

(2) Masked bone conduction testing at those frequencies with air conduction thresholds greater than 20 dB.

(3) Visual inspection of ear canal as appropriate.

(4) Impedance measurements as appropriate.

Case dispositions are handled in the following manner:

(1) Normal cases are deferred.

(2) Conductive cases are referred to the family's private medical doctor.

(3) Sensorineural cases and functional cases are referred for further audiological testing to include speech audiometry.

(4) Questionable cases are referred to county otology clinics.

Otologic Diagnostic Clinic:

Other cases selected for diagnostic evaluation are forwarded to the county health department. The public health nurse contacts the parents in order to interpret the results of the hearing test and to impress upon the family the need for medical diagnosis. The nurse describes the otological clinic program and makes appointments for the child to attend if the family desires this service. Otologic clinics are scheduled in the majority of counties each year and the Hearing Conservation Program staff plans with the county health department for these clinics. Arrangements are made with an otologist to conduct examinations, which are usually held at the county health department locations. Audiologic services also are provided at the otlogic clinic. Before each child is seen by the otologist, he is given another audiometric evaluation which may include a determination of the air and bone conduction threshold and impedance measures. Following the examination, the otologist may make recommendations for medical care, further medical diagnosis, further audiologic assessment or educational evaluation and care. He discusses the results of the examination and his recommendations with the parents. A report of the examination is sent to the family physician, who can provide the recommended care or make referral to an appropriate specialist. A central file of all otologic examinations is maintained by the State Health Division.

### Follow-up After Diagnosis and Care:

The public health nurse is instrumental in the follow-up after the child has been seen for a diagnosis or is undergoing medical treatment. She often needs to interpret the otologist's findings and recommendations. She may also encourage and assist the family in making plans to carry out the recommended treatment. Where there is an economic problem she can assist in requesting help through the appropriate agencies or local organizations.

### Hearing Aid Program for Children:

Hearing aids are available for children as part of the follow-up services of the Hearing Conservation Program. Children who may be eligible for a hearing aid through this program should be referred in the following manner: the child's name, birthdate, address, parent's name, telephone number, and the name or report of the physician or ear specialist treating the child should be forwarded to the Public Health Audiologist.

In addition to the Hearing Aid Program for Children, any child may be referred to the Public Health Audiologist for a detailed hearing evaluation. These tests are available on an appointment basis only and may be obtained by contacting the Hearing Conservation Program.

### Special Educational Services and Adjustment:

Special help may be indicated in cases in which the hearing impairment cannot be returned to normal or near normal. Certain children may need lip reading instructions, speech and language development, auditory training, speech therapy, special classroom seating or hearing aids. The Hearing Conservation Program works in cooperation with the various schools and agencies throughout the State in order to assist children who may require the services of one or more of these agencies. Recommendations of this type are made when it is felt that such help would result in improved communication, education, and social skills.

### Preschool Program:

The audiometrists also provide hearing and vision screening for preschool children ages three to five. Information about this service may be obtained by contacting the local county health department or the Hearing Conservation Program.

### Program Consultation:

Consultation on all of the various aspects of hearing conservation programs is available upon request. Inservice training and workshops are conducted on a periodic basis and may be requested by contacting the Hearing Conservation Program.

OREGON DEPARTM OF EDUCATION
SALEM, OREGON 973

# OREGON SCHOOL H TH RECORD CARD
(FOR USE OF CARD SEE GUIDELINES)

NAME OF PUPIL ______ LAST ______ FIRST ______ M  M ____ F ____ SEX  BIRTH ______ MONTH ____ DAY 19 ____ YEAR

USE PENCIL ONLY

ADDRESS ______ ZIP CODE ______ TEL. NO. ______
PARENTS OR GUARDIANS ______ OCCUPATION OF FATHER ______ OF MOTHER ______
EMERGENCY NAME ______ FATHER'S WORK PHONE ______ MOTHER'S WORK PHONE ______
EMERGENCY NO. ______ HOSPITAL PREFERRED ______
NAME OF PHYSICIAN ______ PHONE ______ OTHER HEALTH PROVIDERS ______

## SCREENING

| SCHOOL YEAR | GRADE | SCHOOL | HEIGHT | WEIGHT | VISION R | VISION L | DENTAL | BLOOD PRESSURE | SCOLIOSIS | AUDIOMETRIC R | AUDIOMETRIC L | HEALTH CARD REVIEW OR OTHER COMMENTS | TOTAL DAYS ABSENT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |
| | | | | | W 20/<br>WO 20/ | W 20/<br>WO 20/ | | | | | | | |

## IMMUNIZATION REQUIREMENTS

| HISTORY | DATE |
|---|---|
| DPT 1st DOSE | |
| DPT 2nd DOSE | |
| DPT 3rd DOSE | |
| DPT BOOSTER NO 1 | |
| DPT BOOSTER NO. 2 | |
| T/d BOOSTER NO. 3* | |
| T/d BOOSTER * | |
| ORAL POLIO 1st DOSE | |
| ORAL POLIO 2nd DOSE | |
| ORAL POLIO BOOSTER NO. 1 | |
| ORAL POLIO BOOSTER NO. 2 | |
| MEASLES VACCINE | |
| MEASLES DISEASE | |
| RUBELLA VACCINE | |
| MUMPS OR MUMPS VACCINE* | |
| | |

COMPLIANCE WITH ORS 433.263 – .275 UPON ENTRY TO SCHOOL

______ DATE/SIGNATURE ______

| | |
|---|---|
| ☐ ALL REQUIRED IMMUNIZATIONS | |
| ☐ ENDANGER TO CHILD'S HEALTH | |
| ☐ RELIGIOUS OBJECTION | |
| ☐ PARTIAL IMMUNIZATIONS | |

*RECOMMENDED BUT NOT REQUIRED.

| OTHER | DATE | | DATE | RESULT |
|---|---|---|---|---|
| | | TB* | | |
| | | | | |
| | | | | |
| | | | | |
| | | XRAY | | |

## SPECIAL HEALTH CONSIDERATIONS

| PROBLEM NO. | DATE IDENTIFIED | PROBLEM | DATE RESOLVED | PROBLEM NO. | DATE IDENTIFIED | PROBLEM | DATE RESOLVED |
|---|---|---|---|---|---|---|---|
| 1 | | | | 4 | | | |
| 2 | | | | 5 | | | |
| 3 | | | | 6 | | | |

## PHYSICAL EXAMINATION

| DATE | EXAM BY | FINDINGS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## HEALTH HISTORY

______
______
______
______

CODE: N-NORMAL OR NO TREATMENT NEEDED R-REFERRED UT-UNDER TREATMENT C-CORRECTED D-DEFERRED OR NO TREATMENT NEEDED AT THIS TIME

FORM 581-3411 (7/79)

| DATE | PROBLEM NO. | HEALTH PROGRESS NOTES |
|---|---|---|
| | | |

| DATE | PROBLEM NO. | CONTINUED |
|---|---|---|
| | | |

**OBSERVATIONS BY TEACHER** | **TEACHER COMMENTS**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| SCHOOL YEAR | 19 | 19 | 19 | 19 | 19 | 19 | 19 | 19 | 19 | 19 | |
| GRADE IN SCHOOL | | | | | | | | | | | |
| STYES | | | | | | | | | | | |
| INFLAMED EYES | | | | | | | | | | | |
| CROSSED EYES | | | | | | | | | | | |
| SQUINTING | | | | | | | | | | | |
| HEADACHES | | | | | | | | | | | |
| DISCHARGE FROM EARS | | | | | | | | | | | |
| EARACHES | | | | | | | | | | | |
| DOES NOT RESPOND TO QUESTIONS | | | | | | | | | | | |
| SPEECH PROBLEM | | | | | | | | | | | |
| MOUTH BREATHING | | | | | | | | | | | |
| SORE THROATS | | | | | | | | | | | |
| COLDS | | | | | | | | | | | |
| INFLAMED GUMS OR LIPS | | | | | | | | | | | |
| DENTAL CARIES | | | | | | | | | | | |
| LOSS IN WEIGHT | | | | | | | | | | | |
| UNUSUAL WEIGHT GAIN | | | | | | | | | | | |
| FATIGUE | | | | | | | | | | | |
| MUSCLE COORDINATION | | | | | | | | | | | |
| POSTURE | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

CODE: N-NORMAL R-REFERRED UT-UNDER TREATMENT C-CORRECTED D-DEFERRED

SAMPLE

## Pupil Medical Record Form

goldenrod form for school entrance

TO BE FILLED IN BY PARENT OR GUARDIAN BEFORE PHYSICAL EXAMINATION: (please print)

________________ (Name of School) ________ (Grade)

Pupil's Name ____________________ Sex M F Birth ________ (Month) (Day) (Year)

Address ____________ (Street or Rural Route) ________ (Town) Home Phone ________

Name of Parent or Guardian ____________ Business Phone of Father ________ of Mother ________

Person to contact in case of emergency and you cannot be reached:

Name ____________ Address ____________ Phone ________

Name of physician to be called in an emergency ____________ Phone ________

Circle the following that your child has now or has had in the past:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Concussion | Yes | No | Year ____ | Operations | Yes | No | Year ____ |
| Skull fractures | Yes | No | Year ____ | Exposure to Tuberculosis | Yes | No | Year ____ |
| Neck injuries | Yes | No | Year ____ | Rubella (3 day Measles) | Yes | No | Year ____ |
| Back injuries | Yes | No | Year ____ | Rubeola (7 day Measles) | Yes | No | Year ____ |
| Muscle, bone, joint | | | | Mumps | Yes | No | Year ____ |
| disease | Yes | No | Year ____ | Rheumatic Fever | Yes | No | Year ____ |
| Skin disorders | Yes | No | Year ____ | Scarlet Fever | Yes | No | Year ____ |
| Eye glasses | Yes | No | Year ____ | Chickenpox | Yes | No | Year ____ |
| Contact lenses | Yes | No | Year ____ | Urinary tract infections | Yes | No | Year ____ |
| Visual treatments | Yes | No | Year ____ | Urinary tract disorder | Yes | No | Year ____ |
| Treatment underway | Yes | No | Year ____ | Allergic disorders: (circle) | | | |
| Hearing treatments | Yes | No | Year ____ | Insect stings Food | | | |
| Treatment underway | Yes | No | Year ____ | Pollens Medicines | | | |
| Hernia | Yes | No | Year ____ | Dust Other ________ | | | |
| Diabetes | Yes | No | Year ____ | Currently on long-term | | | |
| Seizure disorder | Yes | No | Year ____ | medication or shots | Yes | No | Year ____ |
| Fainting spells | Yes | No | Year ____ | Any other significant | | | |
| | | | | defects or illnesses | Yes | No | Year ____ |

Parent's comments on anything checked "Yes" above, as well as any comments regarding behavior and any physical problems or injuries: ________________

### IMMUNIZATIONS

Every child aged 5-14 years entering Oregon public, private, or parochial schools for the first time must present evidence that his or her immunizations are complete and up to date. Exceptions are possible under some circumstances. Your physician or your local health department can provide additional information and assistance with this.

I hereby give permission for my child to receive emergency medical care, and information on this document may be made available to school and health department authorities.

Date ____________ ________________ (Signature of parent or legal guardian)

(OVER)

# PHYSICAL EXAMINATION SUMMARY FOR SCHOOL ENTRANCE AND ATHLETICS

TO BE FILLED OUT AND SIGNED BY EXAMINER:
Measurements: Height ______________ Weight ___________ Blood Pressure ___________
Laboratory: Urinalysis ____________ Hgb/Hct ___________ Other _______________

| Examination | Satis. | Unsatis. | Examination | Satis. | Unsatis. |
|---|---|---|---|---|---|
| Vision | | | Orthopedic | | |
| Hearing | | | Neurological | | |
| Cardiovascular | | | Skin | | |
| Respiratory | | | Physical Maturity | | |
| Liver, spleen, kidney hernia, genitalia | | | Extremities | | |
| | | | Allergies (please list) | | |

Comments on unsatisfactory conditions: ________________________________________

1. Does this child have any condition (such as communicable disease) that would make his/her attending school a problem to the other students? No ___ Yes ___
2. Does this child have any condition(s) that might make attending school a hazard to him/her (chronic debilitating disease, etc.)? No ___ Yes ___
3. Is there anything about this child that would indicate that special attention or special services in school would increase the benefit he/she might receive (hearing or vision deficit, mental retardation, need to limit physical exertion, etc.)?
   No ___ Yes ___

If any of the above are answered "yes," please explain here. Add any other comments.

________________________________________________________________________

________________________________________________________________________

I have on this date, examined the above student and recommend him as being physically able to compete in supervised athletic activities EXCEPT those circled below:

| | | | | | |
|---|---|---|---|---|---|
| BASEBALL | FIELD HOCKEY | GYMNASTICS | SWIMMING | VOLLEYBALL | OTHER ___________ |
| BASKETBALL | FOOTBALL | SOCCER | TENNIS | WRESTLING* | |
| CROSS COUNTRY | GOLF | SOFTBALL | TRACK | SKIING | |

*Student may be permitted weight loss to make a lower weight class in WRESTLING.
Yes ___ No ___ He may not wrestle at less than ______ pounds.

________________________________
(Signature of Examiner)
Address ________________________
City ________________ Phone __________
Date ___________________________

Insurance ______________________________________________

## DENTAL EXAMINATION SUMMARY

Is dental treatment in progress? NO ____ YES ____
Has all necessary dental care been completed? NO ____ YES ____
Remarks: ______________________________________________

________________________________________________________

Date ____________________ ________________________________
(Signature of Dentist)

UPON COMPLETION, THIS FORM IS TO BE RETURNED BY THE STUDENT TO THE SCHOOL

# VISION REFERRAL WORKSHEET

SCHOOL ____________ GRADE ____________ TEACHER ____________ 19 -19 YEAR ____________

| CHILD'S NAME | VISION TEST | | VISION RETEST | | OBSERVATIONS | Parent Referral (date) | COMMENTS |
|---|---|---|---|---|---|---|---|
| | With Glasses | Without Glasses | With Glasses | Without Glasses | Signs and Symptoms | | |
| | R. 20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | | | |
| | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | | | |
| | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | | | |
| | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | | | |
| | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | | | |
| | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | | | |
| | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | | | |
| | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | | | |
| | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | | | |
| | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | | | |
| | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | | | |

(List pupils with 20/40 vision or less or with signs or symptoms such as crossed eyes, tilting head, complaints of blurring, etc.) If a child wears glasses, test with glasses only.

(Continue on reverse side.)

OREGON STATE HEALTH DIVISION
MCH-6 Rev'd 9/73

| CHILD'S NAME | VISION TEST |  | VISION RETEST |  | OBSERVATIONS | Parent Referral (date) | COMMENTS |
|---|---|---|---|---|---|---|---|
|  | With Glasses | Without Glasses | With Glasses | Without Glasses | Signs and Symptoms |  |  |
|  | R. 20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |
|  | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |
|  | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |
|  | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |
|  | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |
|  | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |
|  | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |
|  | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |
|  | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |
|  | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |
|  | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |
|  | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ | R.20/<br>L.20/ |  |  |  |

# REPORT ON SCHOOL VISION SCREENING

Pupil ______________ Birth Date __________ School ______________ Grade ______

Parent's Name ______________________________

Parent's Address ______________________________ City ______________

Dear Parent:

The vision screening test given to ______________________________ (Child's name) indicates that a professional eye examination is advisable. The signs and symptoms which suggest the need for examination are: ______________________________

______________________________

______________________________

Date ______________, 19____. ______________________________ (Teacher or Nurse)

## PARENT'S REPORT OF EYE CARE

Has this pupil had a previous eye examination? ______________________________

Date of last examination ______________ Doctor ______________

Were glasses, treatment or follow-up care recommended at that time? ________ (Explain) ______________

______________________________

______________________________

______________________________

Signed ______________________________ (Parent or Guardian) Date ______________

**NOTE TO PARENT:**

**If your child has had an eye examination within the past year, fill in the above and return it to the school. Otherwise, it should be taken to your doctor.**

(Over)

## REPORT ON EYE EXAMINATION

(To be completed by eye doctor)

Name of Child ______________________________

A. Following an examination of the above-named child, I find the condition described below:

1. Diagnosis ______________________________

2. Is the condition stationary or progressive? ______________________________

3. Were glasses prescribed? Yes_____ No_____

4. Visual Acuity:

| | Distant Vision | | | Near Vision | | |
|---|---|---|---|---|---|---|
| | Without correction | With correction | With low vision aid | Without correction | With correction | With low vision aid |
| Right Eye (O.D.) | | | | | | |
| Left Eye (O.S.) | | | | | | |
| Both Eyes (O.U.) | | | | | | |

5. Other treatment ______________________________

B. Recommendations:

1. When should the child be re-examined? ______________________________

2. What physical activities, if any, should be limited? ______________________________

3. Should use of the eyes be limited? ______________________________

4. If glasses are prescribed, should they be worn all the time? ______________________________

5. General suggestions: ______________________________

Date ____________________

Signed ______________________________ O.D. M.D.

Address ______________________________

PLEASE SEND THIS REPORT TO:

OSHD
MCH-7 9/73

Office of Community Health Services

## OREGON STATE HEALTH DIVISION

## HEARING PROGRAM CASE REPORT

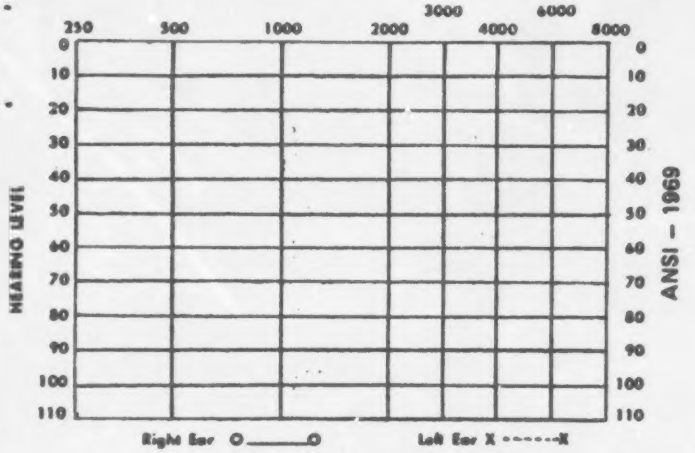
Maternal and Child Health Section

Name ____________ Birth Date ____________ M F Grade ____

School ____________ Town ____________ County ____________

Parent's Name ____________ Address ____________ Phone ____________

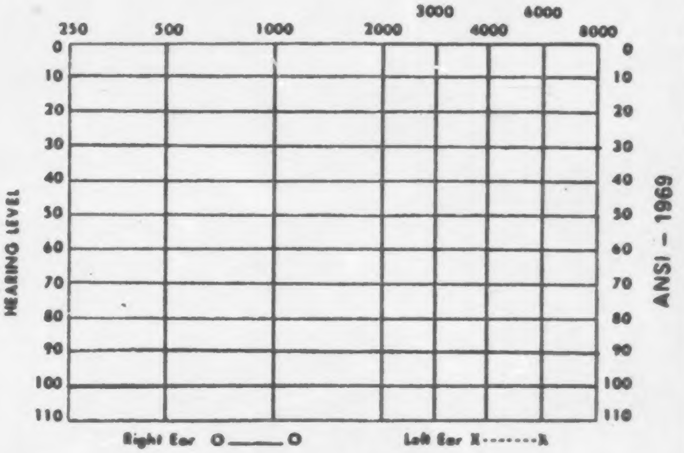
AUDIOGRAM



Right ____________ : ____________ Date ____________

Left ____________ : ____________ Audiometrist ____________

AUDIOGRAM



Right ____________ : ____________ Date ____________

Left ____________ : ____________ Audiometrist ____________

### HISTORY

Previous Treatment (Give approximate date and specify)

Ear ____________

Nose ____________

Throat ____________ T. and A. ____________

Hearing loss suspected ____________

Family history of deafness: Yes ________ No ________

Prenatal: Maternal rubella: Yes ________ No ________

RH Compatibility: Yes ________ No ________

Childhood Diseases, Symptoms, Accidents (Give approximate date)

Measles ____________

Mumps ____________

Allergy ____________

Chicken Pox ____________

Meningitis ____________

Encephalitis ____________

Tonsilitis ____________

Mastoiditis ____________

Other ____________

Earaches: R L When ____________

Draining Ears: R L When ____________

Head Injury ____________

Noise Exposure ____________

Speech or Voice Problem ____________

Undiagnosed Fever ____________

Colds: Occ. ________ Freq. ________

Age Child began to talk ____________

Is child under care of any other agency or program? ____________

Record to be sent to Dr. ____________ Address ____________

### PHYSICIAN'S REPORT OF EAR, NOSE, THROAT EXAMINATION

Ears: Right ____________

Left ____________

Nose: ____________ Nasopharynx: ____________

Throat: ____________ Teeth, Tongue, Palate ____________

Tuning Forks: Rinne R. Pos. ______ Neg. ______ L. Pos. ______ Neg. ______ Weber ______ R ______ L ______ Neither ____________

Diagnosis ____________ Prognosis ____________

____________

Further Special Evaluations (diagnostic, hearing aid, etc.) ____________

Recommended Medical Care ____________ None ____________

Examining Physician's Signature ____________ ____________ Date ____________

# PHYSICIAN'S REPORT OF CARE AND RECOMMENDATIONS

Care Provided ______________________ Date ______________

Further recommendations ______________________________________

______________________________ 
Physician's Signature Date

Return to Local Health Department

89

OREGON STATE HEALTH DIVISION
HEARING CONSERVATION PROGRAM

DIVISION OF PREVENTIVE MEDICAL SERVICES
Maternal and Child Health Section

# TEACHER'S LIST OF PUPILS FOR AUDIOMETRIC TESTS

School ______________________ County ______________________

Teacher's Name ______________________ Room No. __________ Date __________

**To The Teacher:** Please make appropriate notation on this form of any observations made in relation to possible hearing difficulty.

| GRADE | NAME OF PUPIL<br>Please List Alphabetically<br>Last Name First | HEARING STATUS |  |  | REMARKS |
|---|---|---|---|---|---|
|  |  | Normal | Defer | Refer |  |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |
| 7 |  |  |  |  |  |
| 8 |  |  |  |  |  |
| 9 |  |  |  |  |  |
| 10 |  |  |  |  |  |
| 11 |  |  |  |  |  |
| 12 |  |  |  |  |  |
| 13 |  |  |  |  |  |
| 14 |  |  |  |  |  |
| 15 |  |  |  |  |  |
| 16 |  |  |  |  |  |
| 17 |  |  |  |  |  |
| 18 |  |  |  |  |  |
| 19 |  |  |  |  |  |
| 20 |  |  |  |  |  |
| 21 |  |  |  |  |  |
| 22 |  |  |  |  |  |
| 23 |  |  |  |  |  |
| 24 |  |  |  |  |  |
| 25 |  |  |  |  |  |

This is the only record of all pupils tested and will be returned to the school after the testing is completed. The symbols, N; R; and D indicating the hearing status of each child will be recorded on the teachers list in the appropriate column N = Within normal limits D = Hearing loss previously diagnosed, under care, or not medically significant. R = Referral as a medically significant hearing loss. The letter designation N, R, or D should be recorded on the Oregon School Health Record Card in the audiometric test section.

SP*39304-333

MCH-13 [illegible]

## REPORT TO PARENT Regarding Need for Medical or Dental Attention

**(This notification should be sent home in a sealed envelope)**

..............................................................................
Date

Dear ..................................................................,

Observation of your child, ......................................................................................, attending

........................................................................ School, has revealed ...................................

.................................................................................................................................

.................................................................................................................................

Please give this important matter your careful consideration. This form should be presented to your physician or dentist when the child is examined.

Signed ..............................................................................

This report is usually made by the health department after a teacher-nurse conference. When nursing services are not available, reports will be made by the school to the parent.

DH-14—Rev. 9-73
SP*15344-333

(FOLD)

---

## REPORT OF MEDICAL OR DENTAL EXAMINATION

This is to certify that I have examined ...................................................................... and

☐ 1. No treatment is necessary.

☐ 2. Treatment is in progress.

☐ 3. Treatment has been completed.

Further recommendations ........................................................................................

.................................................................................................................................

.................................................................................................................................

**Instructions: This entire record should be sent directly to the school.**

DH-14

..............................................................................
Physician/Dentist Signature

91

# GROWTH CHARTS
# WITH REFERENCE PERCENTILES
# FOR BOYS
# 2 TO 18 YEARS OF AGE

**Stature for Age**
**Weight for Age**
**Weight for Stature**

**NAME** ______________________ **RECORD #** ______________________

**DATE OF BIRTH** ______________________

| Date of Measurement | Age | | Stature | Weight | | |
|---|---|---|---|---|---|---|
| | Years | Months | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

These charts to record the growth of the individual child were constructed by the National Center for Health Statistics in collaboration with the Center for Disease Control. The charts are based on data from national probability samples representative of boys in the general U.S. population. Their use will direct attention to unusual body size which may be due to disease or poor nutrition.

**Measuring:** Take all measurements with the child in minimal indoor clothing and without shoes. Measure stature with the child standing. Use a beam balance to measure weight.

**Recording:** First take all measurements and record them on this front page. Then graph each measurement on the appropriate chart. Find the child's age on the horizontal scale; then follow a vertical line from that point to the horizontal level of the child's measurement (stature or weight). Where the two lines intersect, make a cross mark with a pencil. In graphing weight for stature, place the cross mark directly above the child's stature at the horizontal level of his weight. When the child is measured again, join the new set of cross marks to the previous set by straight lines.

Do not use the weight for stature chart for boys who have begun to develop secondary sex characteristics.

**Interpreting:** Many factors influence growth. Therefore, growth data cannot be used alone to diagnose disease, but they do allow you to identify some unusual children.

Each chart contains a series of curved lines numbered to show selected percentiles. These refer to the rank of a measure in a group of 100. Thus, when a cross mark is on the 95th percentile line of weight for age it means that only five children among 100 of the corresponding age and sex have weights greater than that recorded.

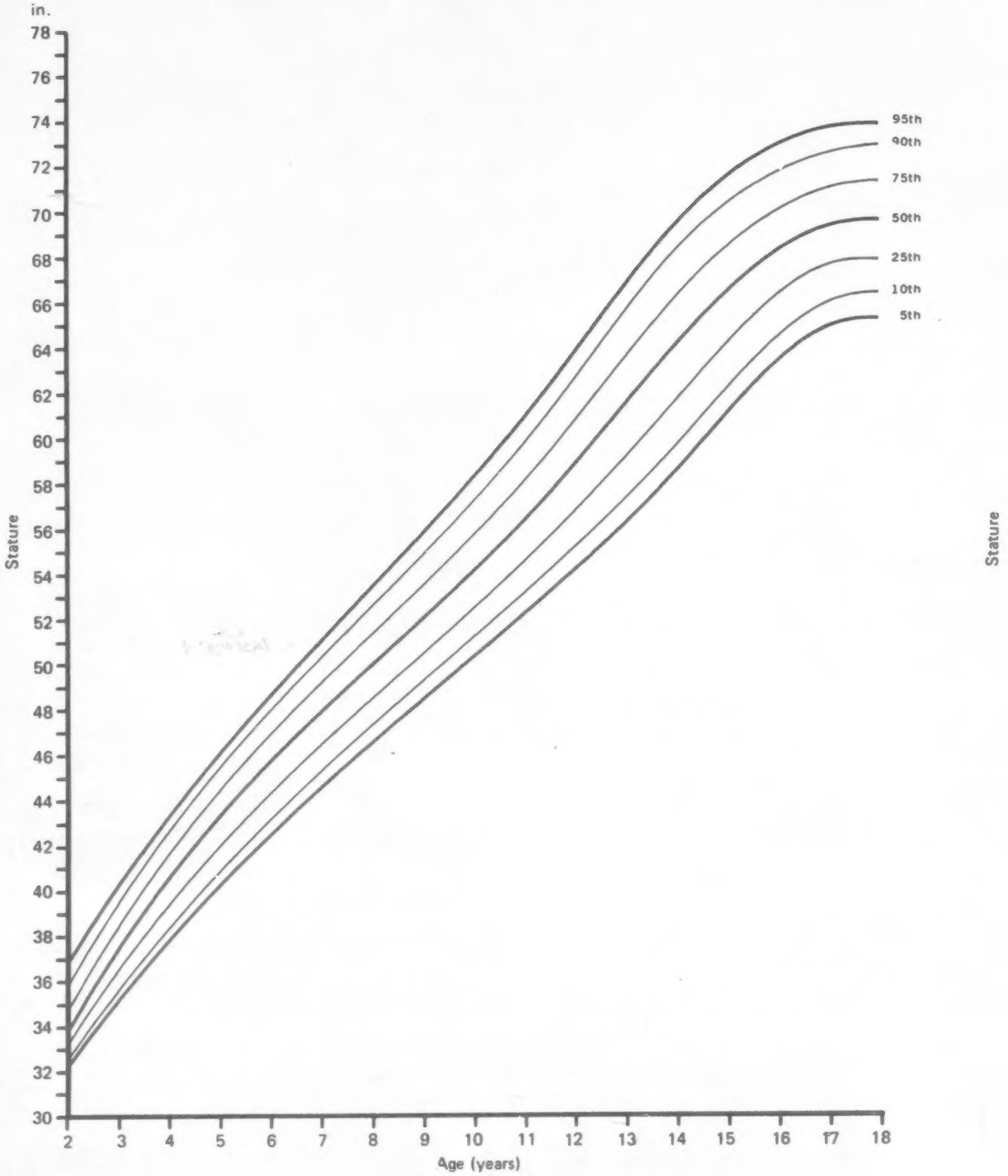
*Inspect* the set of cross marks you have just made. If any are particularly high or low (for example, above the 95th percentile or below the 5th percentile), you may want to refer the child to a physician. *Compare* the most recent set of cross marks with earlier sets for the same child. If he has changed rapidly in percentile levels, you may want to refer him to a physician. Rapid changes are less likely to be significant when they occur within the range from the 25th to the 75th percentile.

In normal teenagers, the age at onset of puberty varies. Rises occur in percentile levels if puberty is early, and these levels fall if puberty is late.

**DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,** PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION, NATIONAL CENTER FOR HEALTH STATISTICS, AND CENTER FOR DISEASE CONTROL

# BOYS FROM 2 TO 18 YEARS

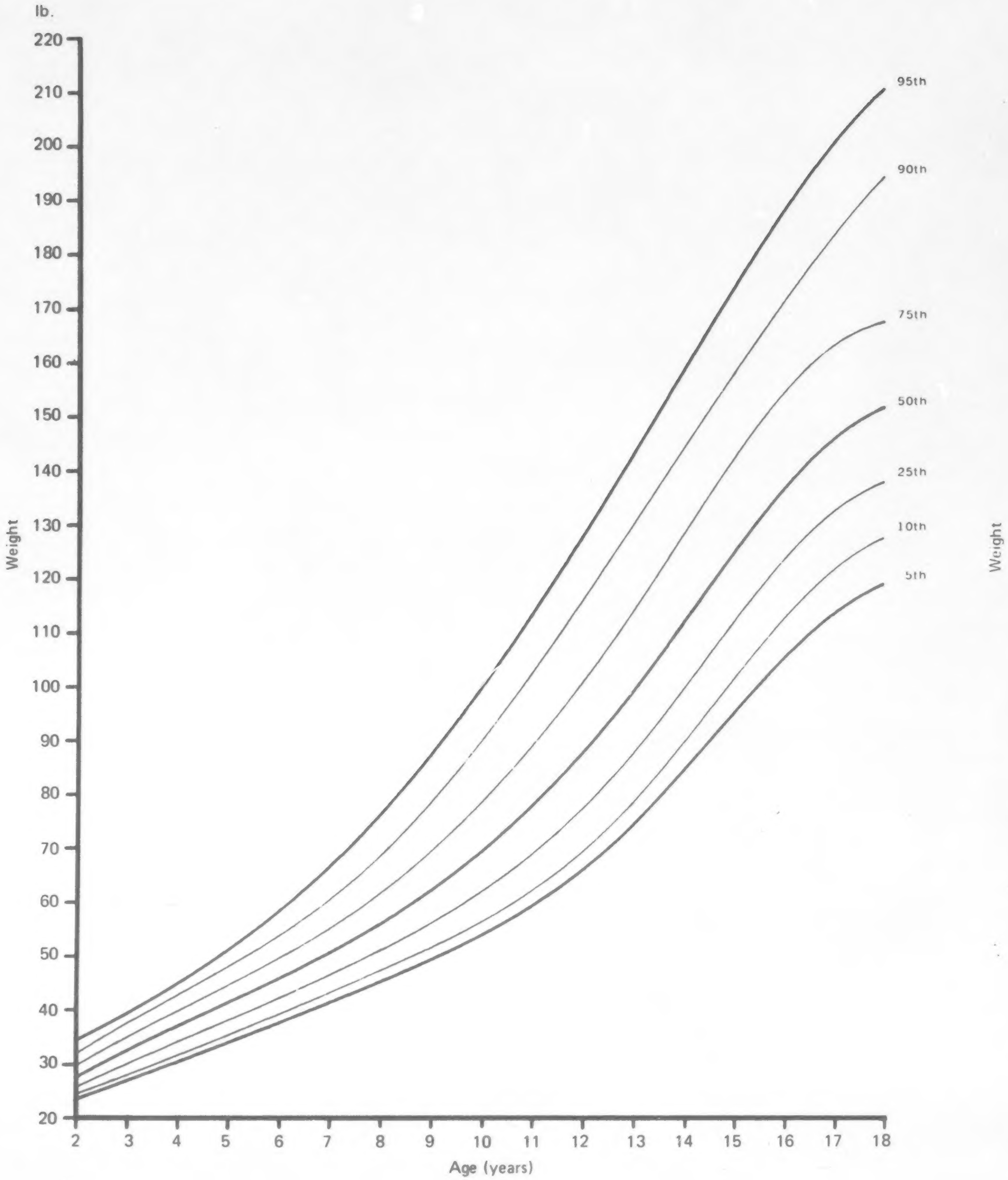
## STATURE FOR AGE



93

## BOYS FROM 2 TO 18 YEARS

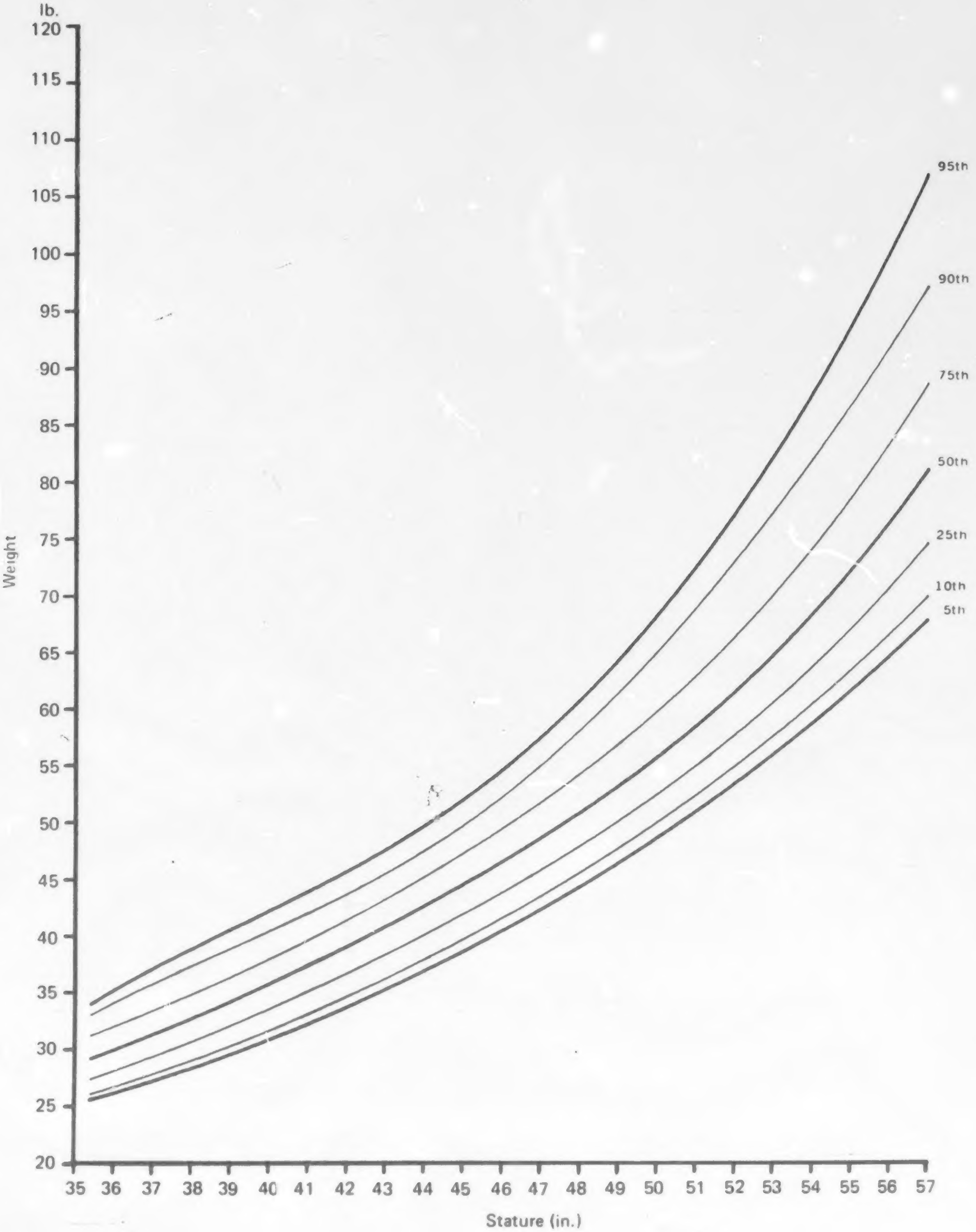
### WEIGHT FOR AGE



94

# PRE-PUBERTAL BOYS FROM 2 TO 1½ YEARS

## WEIGHT FOR STATURE



# GROWTH CHARTS
# WITH REFERENCE PERCENTILES FOR GIRLS
## 2 TO 18 YEARS OF AGE

**Stature for Age**
**Weight for Age**
**Weight for Stature**

**NAME** ______________________ **RECORD #** ______________________

**DATE OF BIRTH** ______________________

| Date of Measurement | Age |  | Stature | Weight |  |  |
|---|---|---|---|---|---|---|
|  | Years | Months |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

These charts to record the growth of the individual child were constructed by the National Center for Health Statistics in collaboration with the Center for Disease Control. The charts are based on data from national probability samples representative of girls in the general U.S. population. Their use will direct attention to unusual body size which may be due to disease or poor nutrition.

**Measuring:** Take all measurements with the child in minimal indoor clothing and without shoes. Measure stature with the child standing. Use a beam balance to measure weight.

**Recording:** First take all measurements and record them on this front page. Then graph each measurement on the appropriate chart. Find the child's age on the horizontal scale; then follow a vertical line from that point to the horizontal level of the child's measurement (stature or weight). Where the two lines intersect, make a cross mark with a pencil. In graphing weight for stature, place the cross mark directly above the child's stature at the horizontal level of her weight. When the child is measured again, join the new set of cross marks to the previous set by straight lines.

Do not use the weight for stature chart for girls who have begun to develop secondary sex characteristics.

**Interpreting:** Many factors influence growth. Therefore, growth data cannot be used alone to diagnose disease, but they do allow you to identify some unusual children.

Each chart contains a series of curved lines numbered to show selected percentiles. These refer to the rank of a measure in a group of 100. Thus, when a cross mark is on the 95th percentile line of weight for age it means that only five children among 100 of the corresponding age and sex have weights greater than that recorded.

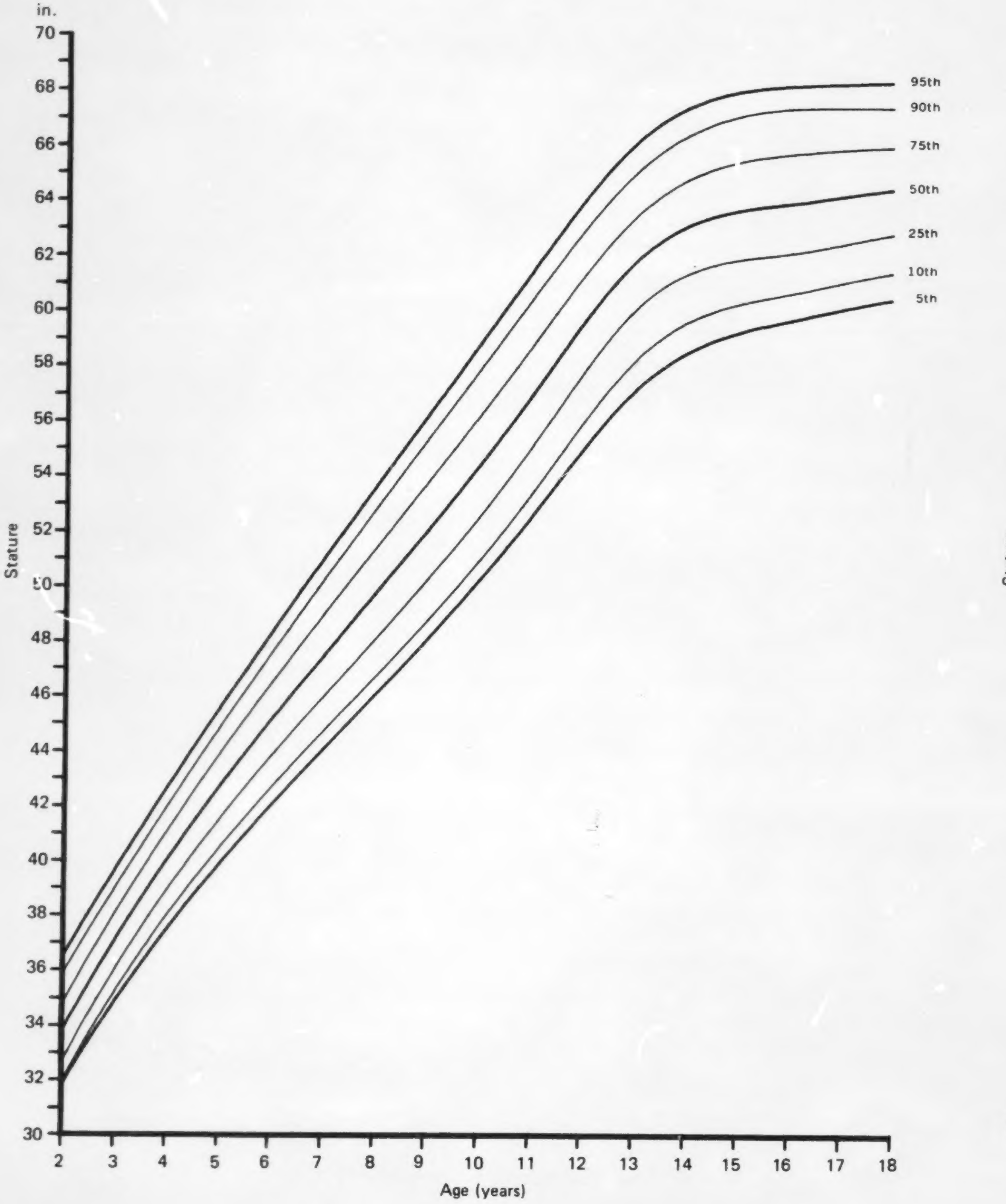
*Inspect* the set of cross marks you have just made. If any are particularly high or low (for example, above the 95th percentile or below the 5th percentile), you may want to refer the child to a physician. *Compare* the most recent set of cross marks with earlier sets for the same child. If she has changed rapidly in percentile levels, you may want to refer her to a physician. Rapid changes are less likely to be significant when they occur within the range from the 25th to the 75th percentile.

In normal teenagers, the age at onset of puberty varies. Rises occur in percentile levels if puberty is early, and these levels fall if puberty is late.

**DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,** PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION, NATIONAL CENTER FOR HEALTH STATISTICS, AND CENTER FOR DISEASE CONTROL

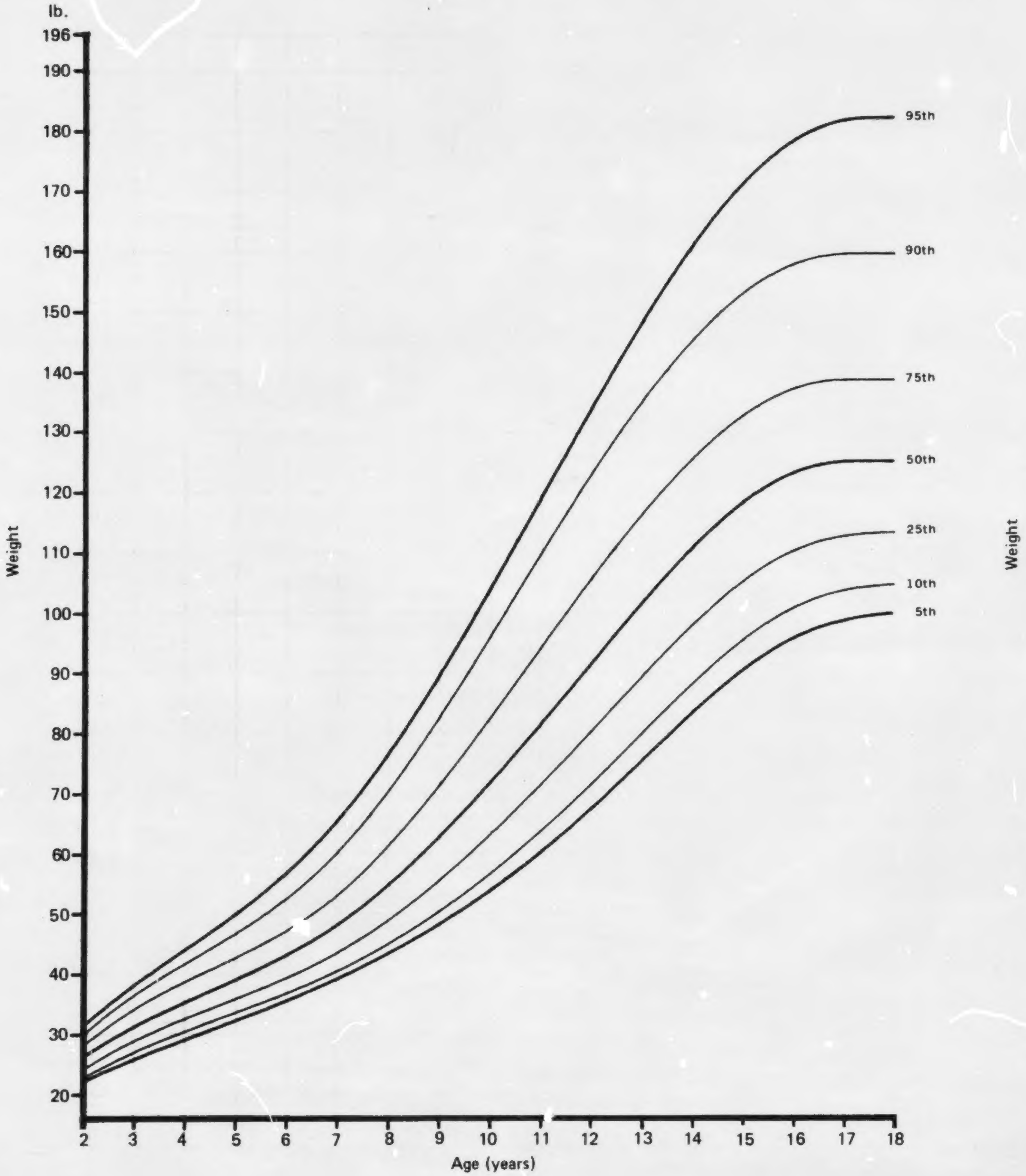
# GIRLS FROM 2 TO 18 YEARS

## STATURE FOR AGE



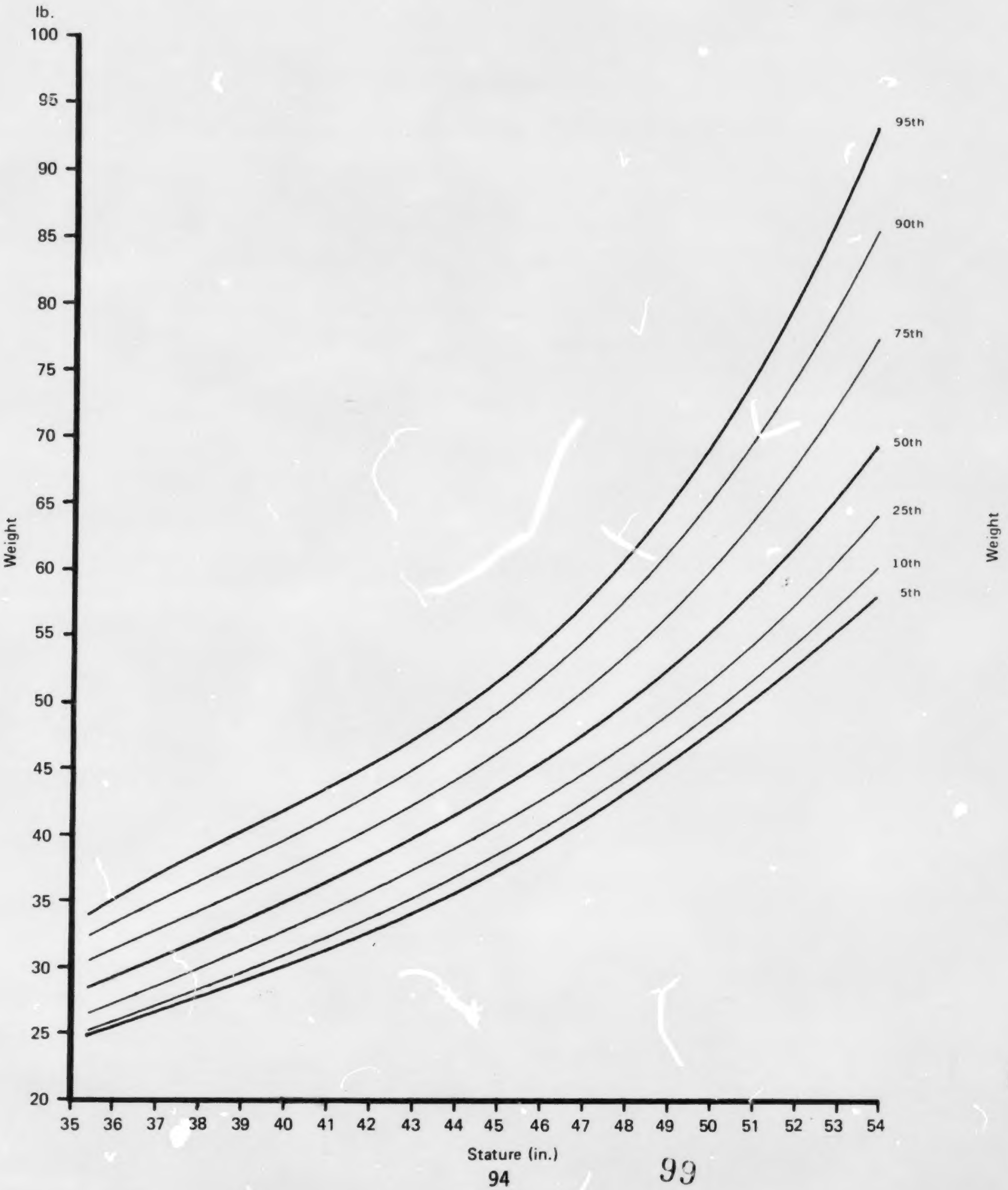
# GIRLS FROM 2 TO 18 YEARS

## WEIGHT FOR AGE



# PRE-PUBERTAL GIRLS FROM 2 TO 10 YEARS

## WEIGHT FOR STATURE



School Building Administration Series 3000*
(Personnel and Building Safety)

## FIRST AID AND EMERGENCY CARE - CONT.

### D. First Aid Equipment and Supplies

1. Each building shall have first aid supplies in accordance to the Oregon State Health Division, Occupational Health Regulations. Subject to said regulations no other items shall be stored in the first aid container without physican's approval.

State Required Items

10 Gauze Pads (at least 3"x3")
2 Gauze Pads (approx. 8"x10")
1 Adhesive Bandages 1"
2 Gauze Bandage 1"
2 Gauze Bandage 2"
2 Triangular Bandages
1 pkg. Wound Cleansing Agent
1 pr. Scissors
1 Blanket (50"x80" min.)

May Be Included in Kit

Splints
Adhesive Tape
Gauze Pads (misc. sizes)
Ammonia Ampoules
Tweezers

2. Supplies shall be kept in a moisture/dust proof container clearly marked and readily accessible, and not locked. Supplies shall be kept in a central area as well as in potentially hazardous areas around the building, such as gymnasium, workshops, science labs, home economics classrooms, art classrooms, and cafeterias.

3. The location of first aid supplies shall be made known to building personnel, and the supplies shall be readily accessible to all.

### E. Emergency Telephone Numbers

The following names and telephone numbers shall be conspicuously posted near the telephone in the main office and by all other "outside" telephones:

1. Fire bureau and police bureau central dispatchers.
2. At least two readily available ambulance companies.
3. All locally available physicians.
4. All area hospitals.

---

*Courtesy of Portland Public Schools: "Policies and Regulations"